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ABSTRACT

Developed in support of state licensing and regulatory agencies as well as state child care, health, and resource and referral agencies, and a variety of other public and private organizations, parents, and advocacy groups, this guide identifies those standards most needed for the prevention of injury, morbidity, and mortality in child care settings. The first section of the guide, "Building: Safety Policies and Practices," addresses topics such as facility access, exits, electrical fixtures, heating and ventilation, fire warning systems, pest control, play areas, water supply, and environmental hazards. The second section, "Other Safety Policies and Practices," addresses topics such as sanitation practices, emergency plans and procedures, first aid, licensing, and illegal drugs. The third section of the guide, "Policies/Practices/Staff Training," addresses topics such as staff ratios, orientation, first aid and CPR training, staff health, background check, child abuse recognition, discipline practices, developmentally appropriate practices, medication administration, confidential information, and release authorization. The final section, "Infection Control," addresses topics such as hand washing, diapering, food safety, reporting communicable diseases, HIV children and staff, drop-in care, ill child exclusion, immunizations, and universal precautions. The appendix consists of a glossary of terms, research methodology, and immunization schedules. (SD)

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Stepping Stones to Using Caring for our Children

National Health and Safety Performance Standards
Guidelines for Out-Of-Home Child Care Programs

Protecting Children From Harm

ED 414 053

PS 026029

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Maternal and Child Health Bureau

Health Resources and Services Administration
Rockville MD 20857

MAR 11 1997

Dear Colleague:

The Maternal and Child Health Bureau (MCHB) is pleased to send you a copy of *Stepping Stones to Using Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-Of-Home Child Care Programs*. *Protecting Children From Harm*. This publication was developed from the *National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs* to identify those standards most needed for the prevention of injury, morbidity and mortality in child care settings.

Stepping Stones was developed in support of state licensing and regulatory agencies as well as state child care, health, and resource and referral agencies, and a variety of other public and private organizations, parents, and advocacy groups. Communities can use *Stepping Stones* to help implement the "Healthy Child Care America Campaign" with its 10-step Blueprint for Action. The campaign promotes a partnership of families, child care and health care providers to support the healthy development of young children in child care and increase access to preventive health services and safe physical environments. Information can be obtained from the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois 60007, phone: (847) 228-5005. The Healthy Child Care America Blue print for Action is also available through the National Child Care Information Center's home page (http://ericps.ed.uiuc.edu/nccic/nccichome.html).

Stepping Stones and the *National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs* are both available on the world wide web through the MCHB supported National Resource Center for Health and Safety in Child Care, located at the University of Colorado, Health Sciences Center, Denver, Colorado (http://nrc.uchsc.edu).

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For questions, please call:
National Resource Center for Health
and Safety in Child Care
University of Colorado, Health Sciences Center
School of Nursing
4200 E. Ninth Avenue
Campus Box C287
Denver, Colorado 80262
Phone: 1-800-598-KIDS
E-mail: Natl.child.res.ctr.@UCHSC.edu

You may also order copies from the:

National Maternal and Child Health
Clearinghouse (NMCC2070)
Chain Bridge Road, Suite 450
Vienna, Virginia 22182-2536
Fax (703) 821-2098

We hope you will find this publication to be a valuable resource in developing policies and regulations, as well as in planning and providing for the health and safety of children in child care settings.

Sincerely yours,

Audrey H. Nora

Audrey H. Nora, M.D., M.P.H.
Assistant Surgeon General
Director

Enclosure

Stepping Stones
to Using
Caring for Our Children

National Health and Safety
Performance Standards
for Out-of-Home Child Care

Sponsored by
Maternal and Child Health Bureau

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Stepping Stones to Using Caring for Our Children was developed by the National Resource Center for Health and Safety in Child Care, located at the University of Colorado Health Sciences Center School of Nursing and funded by the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Health Resources Services Administration.

The National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care (1992), in which these standards first appeared, was initially developed by the American Public Health Association in cooperation with the American Academy of Pediatrics through a grant supported by the Maternal and Child Health Bureau.

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Denver, CO 80262

1-800-598-KIDS
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Preface

In late 1995, the National Resource Center for Health and Safety in Child Care was moved from Georgetown University to the University of Colorado Health Sciences Center. With the move, various projects in progress were also moved. The national comparison matrix project, from which this publication emerged, is one example.

The research methodology which was used to develop the matrix is described by Dr. Richard Fiene on page xi and in Appendix A, page 53. The University of Colorado project team appreciates and acknowledges the meticulous care taken to decide which standards from *"Caring for Our Children"* merited inclusion in this document.

The contribution of personnel at the University of Colorado was to incorporate suggestions made during several expert reviews of the document content, provide editorial transitions and updates, and organize the material so it would have logical "stand-alone" usefulness.

It is hoped that this volume will serve as a reference for individuals and agencies concerned with regulations governing child care settings and practices. Published in this format, this subset of standards can be used for comparing the policies, practices, and regulations with the national standards that have the greatest impact on morbidity and mortality in out-of-home child care.

Marilyn J. Krajicek, Ed.D., R.N., F.A.A.N.
Project Director

Ruth M. Neil, Ph.D., R.N.
Project Coordinator

Dear Colleague:

The Maternal and Child Health Bureau (MCHB) is pleased to offer our latest contribution to the field of health and safety in child care settings, *Stepping Stones to Using Caring for Our Children*. Promoting and protecting the health and safety of young children in child care settings has been a Maternal and Child Health Bureau priority since the early 1980s. The Bureau's efforts in this area include discretionary grants to states and other institutions to improve the health status of young children in out-of-home settings, to develop statewide systems for health and safety in child care settings and to develop the *National Health and Safety Performance Standards -- Guidelines for Out of Home Child Care Programs*. We believe that all of the national health and safety performance standards are important to have in place in a quality child care program. We encourage you to continue your use of this publication as the comprehensive resource document it was intended to be.

Stepping Stones to Using Caring for Our Children was developed from the National Health and Safety Performance Standards to identify those standards most needed for the prevention of injury, morbidity and mortality in child care settings. With the publication of *Stepping Stones to Using Caring for Our Children*, the MCHB offers this document primarily in support of state licensing and regulatory agencies, but also, to state child care, health, and resource and referral agencies, as well as a variety of other public and private organizations, parents, and advocacy groups who need to focus their efforts in order to target limited resources most effectively.

Our sincere appreciation goes to all of our colleagues who willingly gave their time and expertise to the development of this resource. We hope this latest offering provides you the support and assistance needed in your continuing support of the health and safety of children in child care settings.

Phyllis E. Stubbs-Wynn, MD, MPH
Chief, Infant and Child Health Branch
Maternal and Child Health Bureau
Health Resources and Services Administration
Public Health Service
U.S. Department of Health and Human Services

Stepping Stones to Using Caring for Our Children

Steering Committee

Carolyn Acheson
Editorial Consultant
Denver, CO

Susan S. Aronson, M.D. F.A.A.P.
American Academy of Pediatrics
Bryn Mawr, PA

Sue Bredekamp, Ph.D.
National Association for the Education of Young Children
Washington, D.C.

Beverly R. Buck, M.P.A, J.D.
Center for Human Investment Policy
Graduate School of Public Affairs, U.C.D.
Denver, CO

Albert Chang, M.D., M.P.H.
American Public Health Association
San Diego, CA

Jane Coury, M.S.N., R.N.
Project Officer, Maternal and Child Health Bureau
Washington, D.C.

Angela Crowley, M.A.; R.N.,C; C.P.N.P.
Yale University School of Nursing
Orange, CT

Kathy Duran
Illustrator/Designer, Printing
Univ. of Colorado Health Sciences Center
Denver, CO

Karin Eliott, Ed.M.
Former Project Associate
NCEMCH, Georgetown
Washington, D.C.

Richard Fiene, Ph.D.
Department of Psychology
Pennsylvania State University
Harrisburg, PA

Iris-Marie Graville, R.N., M.N.
Public Health Nurse
Whatcom County, WA

Barbara U. Hamilton, M.A.
Resource Librarian
National Resource Center for Health and Safety in Child Care
Denver, CO

Kay Hollestelle, B.A.
Children's Foundation
Washington, D.C.

Moniquin Huggins
Administration for Children and Families
Washington, D.C.

Pauline Koch, M.S.
Office of Child Care Licensing
Wilmington, DE

Marilyn J. Krajicek, Ed.D., R.N., F.A.A.N.
Project Director
National Resource Center for Health and Safety in Child Care
Denver, CO

Carol Logan Kuhns, R.N., Ph.D.
Former Director
Former National Resource Center for Health and Safety in Child Care, Georgetown
Washington, D.C.

Joan Lombardi
Administration for Children and Families
Washington, D.C.

Gwen Morgan, M.S.
Work/Family Directions, Inc.
Boston, MA

Pamela Mangu, M.A.
Former Project Associate
NCEMCH, Georgetown
Washington, D.C.

Ruth M. Neil, Ph.D., R.N.
Project Coordinator
National Resource Center for Health and Safety in Child Care
Denver, CO

Linda J. Romero
Typesetter, Printing
Univ. of Colorado Health Sciences Center
Denver, CO

Denise Sofka, M.P.H., R.D.
Former Project Officer, Maternal and Child Health Bureau
Washington, D.C.

Carolynne H. Stevens
Division of Licensing
Richmond, VA

Phyllis E. Stubbs-Wynn, M.D., M.P.H.
Chief, Infant and Child Health Branch
Maternal and Child Health Bureau
Washington, D.C.

Diana Taxiera
Customer Service Representative, Printing
Univ. of Colorado Health Sciences Center
Denver, CO

Virginia Torrey, B.A.
Administrative Assistant
National Resource Center for Health and Safety in Child Care
Denver, CO

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Acknowledgements

The development of *Stepping Stones to Using Caring for Our Children* has occurred over a three year period during which time more than 256 dedicated and caring individuals generously contributed their time and expertise by participating in the research process and reviewing the content of this document. From the beginning, the project was supported by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) which has consistently encouraged and supported the development of new knowledge and identification of best practices to promote and protect the health, safety and development of children in child care settings.

A special thank you is extended to Ciro V. Sumaya, M.D., administrator of HRSA, Audrey H. Nora, M.D., director of MCHB, David Heppel, M.D., division director for their support and expert counsel. Under the leadership, guidance, and commitment of Phyllis Stubbs-Wynn, M.D., Chief, Infant and Child Health Branch, and her staff including Denise Sofka, MPH, R.D., initially and later Jane Coury, M.S.N., R.N., the path which led to the *"Stepping Stones"* document was completed.

Many individuals and organizations participated in the development of *"Stepping Stones"*. The Steering Committee representing experts in the fields of child care including health and safety in child care development, provided invaluable guidance and expertise in moving the process along. In 1994, the MCHB supported National Resource Center for Health and Safety in Child Care then located at the National Center for Education in Maternal and Child Health (NCEMCH), Georgetown University, began the project under the able leadership of Carol Logan Kuhns, R.N., Ph.D. who was then Project Director. Dr. Kuhns together with Pamela Mangu, M.A. and Karin Eliott, Ed.M. were responsible for the tedious task of overseeing the many steps necessary in selecting the standards to include in this volume.

Dr. Richard Fiene, Ph.D., Department of Psychology, Pennsylvania State University at Harrisburg, served as consultant throughout the project and expertly developed the scientific methodology to assign weights to, and select, the standards.

With a grant from MCHB, the new National Resource Center for Health and Safety in Child Care at the University of Colorado Health Sciences Center, School of Nursing, took over the process in 1996. Under the skillful direction of Marilyn J. Krajicek, Ed.D., R.N., F.A.A.N., Project Director, and Ruth M. Neil, Ph.D., Project Coordinator, *Stepping Stones to Using Caring for Our Children* was completed. Special appreciation needs to be given to the following University of Colorado staff, as well: Beverly Buck, Carolyn Acheson and Barbara Hamilton for writing and editing; Diana Taxiera, Linda Romero and Kathy Duran for typesetting, graphics and lay-out; and Virginia Torrey for administrative support.

Last but not least, special acknowledgment needs to be given to the American Public Health Association and the American Academy of Pediatrics, who had the vision and foresight to partner with the MCHB which in turn funded the development of *Caring for Our Children-National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. It is the quality and comprehensiveness of this hallmark document which allowed the development of the *"Stepping Stones"* to using the full *"Caring for Our Children"*.

INTRODUCTION

"Caring for Our Children", published in 1992, was embraced by the early childhood field as a comprehensive set of national standards for health and safety in child care programs. (Note: this document also was published under an MCHB grant with the title *National Health and Safety Performance Standards -- Guidelines for Out-of-Home Child Care Programs.)* The strength of the national standards is the comprehensive nature of the material. This strength, however, presents somewhat of a challenge to those who use the standards for planning regulatory change or doing regulatory analysis.

To create a planning and regulatory analytical tool from the comprehensive volume of standards, a project was begun in the summer of 1994 to prioritize the standards by risk assessment (morbidity and mortality). *"Caring for Our Children"* contains 981 standards. The question became: Can that number of standards be reduced to 150-200 standards that would serve as the most critical and logical starting points for state administrators planning policy and regulatory revisions, as well as parents, child care and health personnel who are most concerned about protecting children in child care settings from harm.

A modified Delphi approach was employed to accomplish the research task of deciding which standards to include in *Stepping Stones to Using Caring for Our Children*. The process included ten important components which are detailed in Appendix A: Research Methodology.

During the research phase of this project, the document being developed was referred to as the National Comparison Matrix (NCM). The NCM was reviewed by a selected steering committee with representation from the major national groups with an interest in health and safety in child care. After many reviews and revisions the final number of standards was reduced to 182 and are now published as *Stepping Stones to Using Caring for Our Children -- Protecting Children From Harm.*

Richard Fiene, Ph.D.

How "Stepping Stones" Is Organized

The standards in this book have been selected from *"Caring for Our Children"*, also known as the *National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. The standards within the original document are coded and numbered according to the chapter name. The same coding and numbering system has been used in this volume to assist users to locate and refer to the context(s) of the original standards. Users who want to review the rationale and additional information about the standards should consult the original full text document of *"Caring for Our Children"*.

Chapter titles and associated codes are:

1. Staffing	(ST)
2. Program: Activities for Healthy Development	(PR)
3. Program: Health Protection and Health Promotion	(HP)
4. Nutrition and Food Service	(NU)
5. Facilities, Supplies, Equipment and Transportation	(FA)
6. Infectious Diseases	(ID)
7. Children with Special Needs	(CSN)
8. Administration	(AD)
9. Recommendations for Licensing and Community Action	(REC)
Appendix	(APP)

References to specific information in *"Caring for Our Children"* are identified with the abbreviation CFOC.

As is true in the original publication, standards in this book have application to three types of out-of-home child care settings. These are:

- center: a facility that provides care and education for any number of children in a nonresidential setting,
- large family child-care home: usually offers care and education for seven to twelve children (including preschool children of the caregiver) in the home of the caregiver,
- small family child-care home: usually offers care and education for one to six children (including preschool children of the caregiver) in the home of the caregiver.

Symbols denoting the type(s) of facility to which a given standard applies are as follows: If a standard applies only to a center, the symbol appears directly above the standard. If a standard applies to only a large family child-care home, the symbol appears above the standard. If a standard is relevant to only a small family child-care home, the symbol appears above the standard. If all three symbols appear above the standard, the standard applies to all three types of facilities.

BUILDING AND PREMISES: EQUIPMENT SAFETY and PRACTICES

BUILDING: SAFETY POLICIES AND PRACTICES

Access and Exits

CSN54

The center shall be accessible for children who use wheelchairs and for other children with several motor disabilities, in accordance with Section 504 Guidelines *{Editor's Note: of the Rehabilitation Act of 1973}*. Accessibility includes access to buildings, toilets, sinks, drinking fountains, and all classroom and therapy areas. *[Editor's Note: also outside play areas.]* Special provisions shall also be made, as needed, for the child with health, vision, or hearing impairment. *[Editor's Note: See also the rationale to this section, CFOC, p. 257, which states, in part, that it is clear that any facility accepting children with significant motor disabilities will need to be accessible to all children served. Small family home caregivers may be limited in their ability to serve such children, but are not precluded from doing so if there is a reasonable degree of compliance with this Standard. . . . "]*

CSN55

In facilities that include children with physical disabilities, all exits and steps necessary for evacuation shall have ramps approved by the local building authority.

FA22

Each building or structure, new or old, shall be provided with unobstructed exits to allow occupants to escape to an outside door or fire tower in case of fire or other emergency. Each floor above or below ground level used for child care shall have at least two unobstructed exits that lead to an open area at ground level that meets safety requirements for an outdoor play area. Entrance and exit routes shall be reviewed and approved by the local fire inspection authority.

FA23

A facility shall have a minimum of two exits, at different sides of the building or home, leading to an open space at ground level. If the basement in a small family child-care home is being used, one exit must be from the basement.

FA25

Where exits are not immediately accessible from an open floor area, safe and continuous passageways, aisles, or corridors shall be maintained leading to every exit and shall be so arranged as to provide access for each occupant to at least two exits by separate ways of travel.

FA27

Exits shall be clearly visible and the paths of escape shall be so arranged or marked that the path to safety outside is unmistakable.

FA26

No lock or fastening shall be installed.that prevents free escape from the interior of any building. All door hardware in areas used by school-age children shall be within reach of children. In centers, only panic hardware that can be opened by pressure in the direction of travel or single-action hardware (hardware that allows a door to open either way but keeps it from swinging back past the center point) shall be permitted on exterior doors.

FA14

All windows above ground level in areas used by children under 5 years of age shall be constructed, adapted, or adjusted to limit the exit opening accessible to children to less than 6 inches, or be otherwise protected with guards that do not block outdoor light.

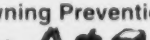
Cribs

FA106

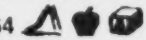
Cribs shall be made of wood, metal, or approved plastic and have secure latching devices. They shall have slats spaced no more than 2 3/8 inches apart, with a mattress fitted so that no more than two fingers can fit between the mattress and the crib side. The minimum height from the top of the mattress to the top of the crib rail shall be 36 inches. Drop-side latches shall securely hold sides in the raised position and shall not be reachable by the child in the crib. Cribs shall not be used with the drop side down. There shall be no corner post extensions (over 1/16 inch) or cut-outs in headboards on the crib.

[Note: See HP93 for resource information on SIDS, CFOC, p. 92.]

Drowning Prevention/Swimming and Tubs

FA263 

All water hazards, such as pools, swimming pools, stationary wading pools, ditches, and fish ponds, shall be enclosed with a fence that is at least 5 feet high and comes within 3-1/2 inches of the ground. Openings in the fence shall be no greater than 3-1/2 inches. The fence shall be constructed to discourage climbing. Exit and entrance points shall have self-closing, positive latching gates with locking devices a minimum of 55 inches from the ground. The child care building wall shall not constitute one side of the fence unless there are no openings in the wall.

FA264 

Above-ground pools shall have nonclimbable sidewalls that are 4 feet high or shall be enclosed with an approved fence as specified in standard FA263. When the pool is not in use, steps shall be removed from the pool or otherwise protected to ensure that they cannot be accessed.

FA273

Each swimming pool more than 6 feet in width, length, or diameter shall be provided with a ring buoy and rope and/or a throw line and a shepherd's hook. Such equipment shall be of sufficient length to reach the center of the pool from the edge of the pool and shall be safely and conveniently stored for immediate access.

[Editor's Note: See also FA266 Safety Covering, FA 269 Pool Equipment and Materials, FA281 Pool Water Quality, CFOC, pp. 193-195.]

FA276

Children shall not be permitted in hot tubs, spas, or saunas.

[Editor's Note: Small portable wading pools are prohibited in standard FA278.]

HP109

Children shall not be permitted to play without constant supervision in areas where there is any body of water, including swimming pools, built-in wading pools, tubs, pails, sinks, or toilets.

[Editor's Note: HP112, CFOC, p. 96, states that "At least one of the caregivers, volunteers, or other adults who are counted in the child:staff ratio for wading and swimming shall be certified in CPR and basic safety ... ."; see also FA271, CFOC, p.194, which requires that an adult who knows the pump's location be present when children are in the pool.

HP111

Preschool children and children with special needs shall not be left unattended in a bathtub or shower.

Electrical Fixtures and Outlets

FA55

Facilities shall be supplied with electric service. Outlets and fixtures shall be installed properly and shall be connected to the source of electric energy in a manner that meets local electrical codes, as certified by an electrical code inspector.

FA56

Electrical outlets accessible to children shall be covered with child-resistant covers or be of the child-proof type. Shock stops (safety plugs) shall be installed on all unused outlets.*[Editor's Note: See also FA59-60 Use of Extension Cords, CFOC, p. 151.]*

FA58

No electrical device or apparatus accessible to children shall be located so that it could be plugged into an electrical outlet while in contact with a water source, such as a sink, tub, shower area, or swimming/wading pool.

FA35

Electric fans, if used, shall be mounted high on the wall or ceiling or shall be guarded to limit the size of the opening in the blade guard to less than 1/2 inch.

Heating, Ventilation,and Cooling

FA31

A draft-free temperature of 65 degrees Fahrenheit to 75 degrees Fahrenheit shall be maintained at 30 to 70 percent relative humidity during the winter months and a draft-free temperature of 68 degrees Fahrenheit to 82 degrees Fahrenheit shall be maintained at 30 to 70 percent relative humidity during the summer months.

FA32

All rooms used by children shall be heated, cooled, and ventilated to maintain the required temperatures, humidity, and air exchange and to avoid accumulation of objectionable odors and harmful fumes.

FA41

Portable, open-flame, and kerosene space heaters shall be prohibited. Portable gas stoves shall not be used for space heating.

FA44

Fireplaces and fireplace inserts shall be screened securely or equipped with protective guards while in use. They shall be properly drafted. The facility shall provide evidence of cleaning the chimney at least once a year, or as frequently as necessary to prevent excessive build-up of combustibles in the chimney.

FA46

Heating units, including water pipes and baseboard heaters hotter than 110°F, shall be made inaccessible to children by barriers such as guards or other devices.

Fire Warning Systems

FA61

Smoke detectors shall be placed on each floor, no more than 40 feet apart, installed on or 6 to 12 inches below the ceiling. Smoke detectors shall be tested monthly, and the batteries replaced at least yearly.
[Editor's Note: See also FA62 Fire Extinguishers, CFOC, p.151.]

Pest Control

FA86

Child play areas shall be kept free of animal wastes, insects, rodents, or other pest infestations, and shall not provide shelter to pests.
[Editor's Note: The rationale for this section refers specifically to uncovered sand box areas as invitations to cat waste, CFOC, p. 155; see HP116-127 Animals, CFOC, pp. 97-98; see also FA87-88 for rodent control, CFOC, p. 155, and FA267 Insect Breeding Hazard, CFOC, p. 193.]

FA92

Pesticides shall be of a type applied by a licensed exterminator in a manner approved by the Environmental Protection Agency. Application shall be directly observed by a member of the child care staff to be sure toxic chemicals applied on surfaces do not constitute a hazard to the children or staff. Pesticides shall be used in strict compliance with the label instructions or as otherwise directed or approved by the regulatory authority. No pesticide shall be applied while children are present.

FA94

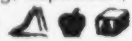
Pesticides shall be stored in their original containers and in a secure site accessible only to authorized staff. No restricted-use pesticide shall be stored or used on the premises except by properly licensed persons.

[Editor's Note: See FA91-96 Extermination, CFOC, pp. 156-157.]

Play Areas/Play Equipment

FA97

Equipment, materials, and furnishings shall be sturdy and free of sharp points or corners, splinters, protruding nails or bolts, loose rusty parts, hazardous small parts, or paint that contains lead or other poisonous materials. The area shall be kept free from small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child.

FA111 

All play equipment shall be constructed and installed in such a manner as to be safe for use by children (e.g., height shall not be excessive; the equipment shall not be a potential source of entrapment). There shall be no pinch, crush, or shear points on or underneath such equipment that would be accessible by children.

FA241

Anchored play equipment shall not be placed over, or immediately adjacent to, hard surfaces.

FA245

All pieces of playground equipment shall be surrounded by a resilient surface (e.g., fine, loose sand; wood chips; wood mulch) of an acceptable depth (9 inches), or by rubber mats manufactured for such use, consistent with the guidelines of the Consumer Product Safety Commission and the standards of the American Society for Testing and Materials, extending beyond the external limits of the piece of equipment for at least 4 feet beyond the fall zone of the equipment. These resilient surfaces must conform to the standard stating that the impact from falling will be less than or equal to peak deceleration 200G. Organic materials that support colonization of molds and bacteria shall not be used.

[Editor's Note: See Appendix O-3 Critical Heights of Tested Materials, CFOC, p. 362.]

FA246

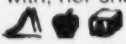
All pieces of playground equipment shall be designed so that moving parts (swing components, teeter-totter mechanism, spring-ride springs, etc.) will be shielded or enclosed.

FA248

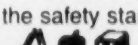
All pieces of playground equipment shall be designed to guard against entrapment or situations that may cause strangulation by being made too large for a child's head to get stuck or too small for a child's head to fit into. Openings in exercise rings shall be smaller than 4-1/4 inches or larger than 9 inches in diameter. There shall be no openings in a play structure with a dimension between 4-5/8 inches and 9-1/8 inches. In particular, side railings, stairs, and other locations where a child might slip or try to climb through shall be checked for appropriate dimensions. Protrusions such as pipes or wood ends that may catch a child's clothing are prohibited. Distances between vertical infill, where used, must be 4-5/8 inches or less to prevent entrapment of a child's head. No opening shall have a vertical angle of less than 55 degrees. To prevent finger entrapment, no opening larger than 3/8 inch and smaller than 1 inch shall be present.*[Editor's Note: See generally {Editor's Note: The current Handbook for Public Playground Safety, U.S. Consumer Product Safety Commission, recommends that dimensions to be used for head entrapment prevention be altered to 3 1/2" minimum and 9" maximum.]*

FA257

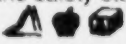
Outdoor play equipment that is accessible to children shall not be coated or treated with, nor shall it contain, toxic materials in hazardous amounts.

FA256 

All outdoor activity areas shall be maintained in a clean and safe condition by removing debris, dilapidated structures, broken or worn play equipment, building supplies, glass, sharp rocks, twigs, toxic plants, and other injurious material. The play areas shall be free from anthills *[Editor's Note: or other visible insect hazards, e.g., wasps' nest]*, unprotected ditches, wells, holes, grease traps, cisterns, cesspools, and unprotected utility equipment. Holes or abandoned wells within the site shall be properly filled or sealed. The area shall be well drained with no standing water.*[Editor's Note: See references in "Pest Control" above.]*

FA223 

A rooftop used as a play area shall be enclosed with a fence not less than 6 feet high and designed to prevent children from climbing it. An approved fire escape shall lead from the roof to an open space at the ground level that meets the safety standards for outdoor play areas.

FA204 

Strings and cords (e.g., those that are parts of toys, or those that are found on window shades) that are long enough to encircle a child's neck (6 inches or more) shall not be accessible to children in child care.

FA211

Small objects, toys, and toy parts available to infants and toddlers shall meet the federal small parts standards for toys. Toys or objects having a diameter less than 1-1/4 inch, objects with removable parts and a diameter less than 1-1/4 inch, toys with sharp points and edges, plastic bags, and styrofoam objects shall not be accessible to children under 4 years of age.

FA214

Infants, toddlers, and preschool children shall not be permitted to inflate balloons, nor shall they have access to deflated or under-inflated balloons.

FA322

All children and adults shall wear approved safety helmets while riding bicycles. Approved helmets shall meet either the American National Standards Institute (ANSI) Z90.4 or Snell Memorial Foundation Standard.
[Editor's Note: Safety helmets are recommended for skateboards and rollerblade/in-line skates; see also Consumer Product Safety Commission Document #5014, June 1995, the CPSC recommends use of safety gear to help prevent injuries with in-line skate/roller blades. A helmet, elbow pads, knee pads, wrist guards, and gloves should always be worn.]

Water Supply

FA66

There shall be no cross-connections that could permit contamination of the potable water supply

(a) Back-flow preventers, vacuum breakers, or strategic air gaps shall be provided for all boiler units in which chemicals are used.
(b) Vacuum breakers shall be installed on all threaded hose bibs.
(c) Nonsubmersible, antisiphon bullocks shall be provided on all flush-tank-type toilets.

FA70

In both private and public drinking water supplies where interior or service piping or joint seals contain lead or other toxic materials, water shall be evaluated at the beginning of operation and at least every 2 years by the local health authority to determine safe lead levels. Such samples shall consist of the first draw of water in the facility after at least a 6-hour lapse in use.

FA63

Every facility shall be supplied with piped running water under pressure, from a source approved by the Environmental Protection Agency (EPA) and/or the state or local health authority, to provide an adequate water supply to every fixture connected with the water supply and drainage system. When water is supplied by a well or other private source, it shall meet all applicable federal, state, and local health standards and shall be approved by the local health department or its designee prior to use. Any facility not served by a public water supply shall keep documentation of approval of the water supply on file.

Sewage

FA74

Where public sewers are not available, a septic tank system or other method approved by the state or local health department or its designee shall be installed.

FA75

Raw or treated wastes shall not be discharged on the surface of the ground.

Toilets/Bathrooms

FA141

Toilets shall be located in rooms separate from those used for cooking or eating. If toilets are not on the same floor as the child care area, an adult shall accompany children less than 5 years of age to and from the toilet area.

[Editor's Note: See also HP110 Water Safety, which states that "all young children shall be supervised while using bathroom facilities, but children under 3 shall be supervised especially closely," CFOC, p. 96.]

Environmental Hazards

FA206

The center shall not have any firearms, pellet or BB guns (loaded or unloaded), darts, or cap pistols within the premises at any time. Such materials, if present in a small or large family child-care home, must be unloaded and kept under lock and key in areas inaccessible to the children. *[Editor's Note: Parents will be informed if guns or ammunition are kept in the facility. Firearms & ammunition to be stored separately).]*

FA201

Matches and lighters shall be inaccessible to children.

FA202

Gasoline and similar flammable materials shall be stored away from the children in a separate building.

FA203

Thin plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, shall be stored out of reach of children.

FA205

Environmental hazards, such as pits, abandoned wells, and abandoned appliances, that present a risk for entrapment or inhumation (burial) shall be covered or made inaccessible to children.

FA137

Construction, remodeling, or alterations of structures during child care operations shall be done in such a manner as to prevent hazards or unsafe conditions (e.g., fumes, dust, safety hazards).

Toxic Substances

FA84

Infectious and toxic wastes shall be stored separately from other wastes and disposed of in a manner approved by the local health authority.

FA120

Cleaning materials, detergents, aerosol cans, pesticides, health and beauty aids, poisons, and other toxic materials shall be stored in their original labeled containers and shall be used according to the manufacturer's instructions and the intended purpose. They shall be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute hazard to the children. When not in actual use, such materials shall be kept in a place inaccessible to children and separate from stored medications and food.*[Editor's Note: See FA92 and FA94, p.5.]*

FA121

The poison control center and/or physician shall be called for advice about safe use of any toxic products (e.g., pesticides, plants, rat poison) or in any ingestion emergency, and advice from the poison control center shall be documented in the facility's files. The poison information specialist and/or physician shall be told the child's age and sex, the substance swallowed and the estimated amount, and the child's condition.

FA123

When the manufacturer's Material Data Safety Sheet shows the presence of any toxic effects, these materials shall be replaced with non-toxic substitutes. If no substitute is available, the product shall be eliminated.

NU92

When cleaning agents cannot be stored separately and must be stored in the same room with food, these supplies shall be clearly labeled and kept separated from food items in separate cabinets that are inaccessible to children.

FA125

Any asbestos that is friable or in a dangerous condition found within a facility shall be removed by a contractor certified to remove asbestos, encapsulated or enclosed, in accordance with existing regulations of the Environmental Protection Agency (EPA), the federal agency responsible for asbestos abatement.

FA128

Chemicals used in lawn care treatments shall be limited to those listed as non-restricted use. All chemicals used inside or outside shall be stored in their original containers in a safe and secure manner, accessible only to authorized staff. They shall be used only according to manufacturer's instructions, and in a manner that will not contaminate play surfaces or articles.

[Editor's Note: The Environment Protection Agency has a list of restricted chemicals unsuitable for use in a child care environment.]

FA130

Poisonous or potentially harmful plants on the premises shall be inaccessible to children. All plants accessible to children shall be identified and checked by name with the local poison control center to determine safe use.

[Editor's Note: See also Appendix N About Poisonous Plants, CFOC, p. 357.]

FA136

No paint containing lead in excess of 0.06 percent shall be used when surfaces are repaired or when any new surfaces accessible to children are painted.

[See U.S. Consumer Product Safety Commission Release # 96-150, 6/25/96 on imported mini blinds. The CPSC found that over time the plastic deteriorates from exposure to sunlight and heat to form lead dust on the surface of the blind. The amount of lead dust that formed from the deterioration varied from blind to blind. CPSC found that in some blinds, the levels of lead in the dust was so high that a child ingesting dust from less than one square inch of blind a day for about 15 to 30 days could have blood levels at or above the 10 microgram, per-deciliter amount CPSC considers dangerous for young children. Washing the blinds does not prevent the vinyl blinds from deteriorating. Children can ingest lead dust on the surface by wiping their hands on the blinds and then putting their hands in their mouth. CPSC recommends that consumers with young children ages 6 and younger remove old vinyl miniblinds and replace them with new miniblinds made without added lead or with alternative window coverings.]

FA236

The soil in play areas shall not contain hazardous levels of any toxic chemicals or substances. The facility shall have soil samples and analyses performed by the local health department, extension service, or environmental control testing laboratory, as required, if there is good reason to believe a problem may exist.

OTHER SAFETY POLICIES AND PRACTICES

Cleaning and Sanitation Practices

HP40

Toilet rooms, flush toilets, toilet-training equipment, and fixtures shall be cleaned and sanitized at least daily and when obviously soiled, and shall be in good repair.

HP41

If potty chairs are used, they shall be emptied into a toilet, cleaned in a utility sink, sanitized after each use, and stored in the bathroom, where feasible.

HP47

Indoor environmental surfaces associated with children's activities, such as table tops, shall be cleaned and disinfected when they are soiled or at least once weekly.

HP51

All frequently touched toys in rooms in which infants and toddlers are cared for shall be cleaned and disinfected daily.

HP54

Thermometers, pacifiers, and other such objects shall be cleaned and disinfected between uses by different children.

HP43

Disposable towels or clean, reusable towels laundered between uses shall be used for cleaning. Disposable towels shall be sealed in a plastic bag and removed to outside garbage. Cloth towels shall be placed in a closed, foot-operated receptacle until laundering.

HP39

The frequency of cleaning, sanitation and disinfection in the facility shall be increased from baseline routine frequencies specified in Maintenance for Safety, and Hygiene, to the frequency specified by the local health department when necessary to control infectious disease.

[Editor's Note: See FA292-302 Maintenance for Safety, CFOC, pp.197-198; HP29-32 Hygiene, CFOC, pp.72-74; see also Glossary, "Clean," "Disinfect".]

Posted Documents

APP33

Each center shall post the following in a conspicuous public place clearly visible to parents, caregivers, and visitors:

(a) The center's license or registration (which also includes the telephone number for filing complaints with the regulatory agency), as specified in Licensing and Legal Records.

(b) A statement informing parents/legal guardians about how they may obtain a copy of the licensing or registration requirements from the regulatory agency.

(c) Information on procedures for filing complaints with the regulatory agency.

(d) Inspection and any accreditation certificates, as specified in Licensing and Legal Records.

(e) Reports of any legal sanctions, as specified in Licensing and Legal Records.

(f) A notice that inspection reports, legal actions, and compliance letters are available for inspection in the facility.

(g) Evacuation plan, as specified in standard AD31.

(h) Fire evacuation procedures. (These shall be posted in each room of the center.)

(i) Procedures for the reporting of child abuse consistent with state law and local law enforcement and child protective service contact

(j) A notice announcing the "open-door policy" (that parents may visit at any time and will be admitted without delay) and action the facility will take to handle a visitor's request for access if the caregiver is concerned about the safety of the children.

(k) A class roster in each facility room that lists the names of all children assigned to that room and the name of the caregiver primarily responsible for each child.

(l) A current weekly menu for parents and caregivers. The facility shall provide copies to parents, if requested. Copies of menus served shall be kept on file for 1 year.

(m) A copy of the policy and procedures for discipline, including the prohibition of corporal punishment. This requirement also applies to school-age child care facilities.

(n) Legible safety rules for the use of swimming pools, and built-in wading pools.

(o) Phone numbers and instructions for contacting the fire department, police, emergency medical services, physicians, dentists, rescue and ambulance services, and the poison control center; the address of the facility, and directions to the facility from major routes north, south, east, and west. This information shall be conspicuously posted adjacent to the telephone.

(p) A list of reportable communicable diseases as required by the state and local health authorities.

[Editor's Note: See AD76-79 Licensing and Legal Records, CFOC, pp. 292-293, and AD31-35 Evacuation Plan and Drills, CFOC, pp. 280-281.]

Emergency Plans

AD31

The facility shall have a written plan for reporting and evacuating in case of fire, flood, tornado, earthquake, hurricane, blizzard, power failure, or other disaster that could create structural damages to the facility or pose health hazards. The facility shall also include procedures for staff training on this emergency plan.

AD33

The center director shall use a daily class roster in checking the evacuation and return to a safe indoor space of all children in attendance during an evacuation drill. Small and large family home caregivers shall count to be sure that all children are safely evacuated and returned to a safe indoor space during an evacuation drill.

AD34

A fire evacuation procedure shall be approved by a fire inspector and shall be practiced at least monthly from all exit locations at varied times of the day and during varied activities, including naptime.

[Editor's Note: See section "Fire Warning Systems" in this document, p.4-5; see also AD31-35 Evacuation Plan and Drills and AD36-43 Safety Plan, CFOC, pp. 280-283. Experts have suggested that the emergency plan also address where children might be taken/phone contact in case of emergency.]

APP28

The facility shall have a written plan for reporting and managing any incident or unusual occurrence that is threatening to the health, safety, or welfare of the children or staff. The facility shall also include procedures for staff training on this emergency plan. The following incidents, at a minimum, shall be addressed in the emergency plan.

(a) Lost or missing child.

(b) Sexual or physical abuse or neglect of a child (as mandated by state law).

(c) Injuries requiring medical or dental care.

(d) Serious illness requiring hospitalization, death of a child enrolled in the facility, or death of a caregiver, including deaths that occur outside of child care hours.

The following measures, at a minimum, shall be addressed in the emergency plan *[Editor's note: or urgent care plan]*:

(e) Provision for a caregiver to accompany a child to the emergency care source and remain with the child until the parent or legal guardian assumes responsibility for the child. Provision for a backup caregiver or substitute for large and small family child-care homes to make this feasible. Child:staff ratios must be maintained at the facility during the emergency.

(f) The source of emergency medical care—a hospital emergency room, clinic, or other constantly staffed facility known to caregivers and acceptable to parents.

(g) Resupply of first aid kits following each first aid incident, and maintenance of required contents in a serviceable condition, by a periodic review of the contents.

(h) The names and addresses of at least three licensed providers of dental services who have agreed to accept emergency dental referrals of children and to give advice regarding dental emergency.

CSN91

Facilities providing services to children with special needs shall have a written plan for emergency medical backup and medical procedures. This plan shall:

(a) Describe for each child with special needs the special emergency procedures that will be used if required by the caregiver or by a physician or registered nurse available to the caregiver.

(b) Note any special medical procedures, if required by the child's condition, that will be used with the child while he/she is in the care of the caregiver.

CSN92

A copy of the plan shall be made available to the parents of each child with special needs. The plan shall be revised each time a new child with special needs enters the care of the caregiver, or when any child's medical condition changes.

CSN64

The feeding plan shall include steps to take when problems occur that require rapid response (e.g., when a child chokes during mealtime). The completed plan shall be on file and accessible to staff.

Emergency Procedures

AD43

The facility shall provide a telephone as specified in Facility Furnishings and Equipment *[Editor's Note: FA97-101 Facility Furnishings & Equipment Requirements, CFOC, pp. 157-162; experts have also suggested use of a cellular phone for field trips* and posting of emergency telephone numbers and instructions as specified in Appendix W, *APP 33-34," Posting Documents, CFOC, pp. 385-86.]*

HP105

When an immediate response is required, the following emergency procedures shall be utilized:

(a) First aid and CPR care shall be employed, and the emergency medical response team shall be called, as indicated. *[Editor's Note: With healthy children, cessation of breathing almost always precedes cardiac arrest, so that rescue breathing, not including cardiac resucitation, is usually sufficient to revive the child.]*

(b) The facility shall have a plan for emergency transportation to a local hospital or health care facility.

(c) The parent or parent's emergency contact person shall be called.

[Editor's Note: See also ST44-46 First Aid and CPR, CFOC, pp. 22-24, Appendix H Get Medical Help Immediately, CFOC, p. 342; see also page 21 of this document.]

AD72

The facility shall document that a child's parent or legal guardian was notified immediately of an injury or illness that required professional medical attention.

HP93

If a facility experiences the death of a child *[Editor's Note: or staff]*, the following shall be done:

(a) If the child dies while at the facility:

(1) Immediately notify emergency medical personnel.

(2) Immediately notify the child's parents.

(3) Notify the licensing agency.
(4) Provide age-appropriate information for children and parents.

(b) For a Sudden Infant Death Syndrome (SIDS) death:
(1) Seek support and SIDS information from local, state, or national SIDS resources.
(2) Provide SIDS information to the parents of the other children in the facility.
(3) Provide age-appropriate information to the other children in the facility.

(c) If the child dies while not at the facility:
(1) Provide age-appropriate information for children and parents.
(2) Make resources for support available to parents and children.

[Editor's Note: See HP93 for resource information on SIDS, CFOC, p. 92.]

First Aid Supplies

FA116

Two readily available first aid kits shall be maintained by each facility, one to be taken on field trips and outings away from the site. Each kit shall be a closed container for storing first aid supplies, accessible to child care staff members at all times but out of reach of children. First aid kits shall be restocked after use, and inventory shall be conducted at least monthly. The first aid kits shall contain at least the following items:

(a) Disposable nonporous gloves.
(b) Sealed packages of alcohol wipes or antiseptic.
(c) Scissors.
(d) Tweezers.
(e) Thermometer.
(f) Bandage tape.
(g) Sterile gauze pads.
(h) Flexible roller gauze.
(i) Triangular bandages.
(j) Safety pins.
(k) Eye dressing.
(l) Pen/pencil and note pad.
(m) Syrup of ipecac.
(n) Cold pack.
(o) Current American Academy of Pediatrics or American Red Cross standard first aid text or equivalent first aid guide.
(p) Coins for use in a pay phone.
(q) Insect sting preparation. *[Editor's Note: Including EPIPEN ® if child with known insect bite allergy is present]*
(r) Poison control center telephone number.
(s) Water.
(t) Small plastic or metal splints.
(u) Soap.
(v) *[Editor's Note: Airway and resuscitation barrier mask.]*
(w) *[Editor's Note: Cellular phone for field trips.]*
(x) *[Editors Note: Any emergency medication needed for child with special health needs.]*

PR30
First aid kits shall be taken on field trips (as specified in standard FA116).

Prohibition of Tobacco, Alcohol, Illegal Drugs

AD49
Facilities shall have written policies specifying that smoking, use of alcohol, and use or possession of illegal substances or unauthorized potentially toxic substances are prohibited in the facility when children are in care.
[Editor's note: Promote a smoke-free environment.]

HP128
The use of tobacco (in any form), alcohol, and illegal drugs shall be prohibited on the facility premises during the hours of operation.

Transportation

FA317
When children are driven in a motor vehicle other than a bus or school bus operated by a common carrier, the following shall apply:

(a) A child may be transported only if the child is fastened in an approved safety seat, seat belt, or harness appropriate to the child's weight, and the restraint is installed and used in accordance with the manufacturer's instructions; each child must have an individual seat belt.

(b) A child under the age of 4 shall be transported only if the child is securely fastened in a child passenger restraint system that meets the federal motor vehicle safety standards contained in the Code of Federal Regulations, title 49, section 571.213, and this compliance is so indicated on the safety restraint device.

(c) If small buses or vans have safety belts installed, the belts shall be used by the children.

ST3
Child:staff ratios established for out-of-home child care shall be maintained on all transportation provided or arranged by the facility. No child of any age shall be left unattended in a vehicle.

CSN51
Vehicles shall accommodate the placement of wheelchairs with four tie-downs affixed according to manufacturer's instructions. The wheelchair occupant shall be secured by the wheelchair restraining belt during transport.

FA309
The vehicle shall be driven by a person who holds a current state driver's license that authorizes the driver to operate the vehicle driven.

FA314

Drivers shall not have used alcohol within 12 hours prior to transporting children. The use of illegal drugs by drivers shall be prohibited. Drivers shall ensure that any prescription drugs will not impair their ability to drive. The center director shall require drug testing when noncompliance is suspected.

Facility Licensing/Registration

AD76

Every facility shall hold a valid license or registration.

AD78

When deficiencies are identified during annual policy and performance reviews by the licensing department, funding agency or accreditation organization, the director or small or large family home caregiver shall follow a written plan for resolution, outlined with the regulatory agency. This plan shall include the following: a description of the problem; a proposed timeline for resolution; designation of responsibility for correcting the deficiency; and a description of the successful resolution of the problem. For centers, this shall be a written plan.

POLICIES/PRACTICES/STAFF TRAINING

Policy/General

AD2

The administrator of a facility shall see to it that policies that promote the achievement of quality child care are developed, and shall also ensure stable and continuing adherence to all policies. When problems are identified, the administrator shall be responsible for a follow-up plan to be sure that corrective action was taken and assign a person to correct the problem by a specified date.

Child: Staff Ratios and Group Size

ST2

Child:staff ratios for center and large family child-care homes shall be maintained as follows during all hours of operation:

Age	*Child:Staff Ratio*	*Maximum Group Size*
Birth-12 mos.	3:1	6
13-24 mos.	3:1	6
25-30 mos.	4:1	8
31-35 mos.	5:1	10
3-year-olds	7:1	14
4-year-olds	8:1	16
5-year-olds	8:1	16
6-8-year-olds	10:1	20
9-12-year-olds	12:1	24

When there are mixed age groups in the same room, the child:staff ratio and group size shall be consistent with the age of the majority of the children when no infants or toddlers are in the mixed age group. When infants and toddlers are in the mixed age group, the child:staff ratio and group size for infants and toddlers shall be maintained.

In large family child-care homes with two or more caregivers caring for no more than twelve children, there shall be no more than three children under the age of 2.
[Editor's Note: See PR12, which states, in part, that [caregivers of infants shall not be responsible for the care of older children who are not part of the infants' closed child care group, CFOC, p. 48.]

AD9

Each facility's supervision policy shall specify:

(a) That no child shall be left alone or unsupervised while under the care of the child care staff. Caregivers shall supervise children at all times, even when the children are sleeping (a caregiver must be able to both see and hear infants while they are sleeping). Caregivers shall not be on one floor while children are on another floor. School-age children shall be permitted to participate in activities and visit friends off premises as approved by their parents and by the caregivers(s).

(b) That developmentally appropriate child:staff ratios shall be met during all hours of operating, including field trips.

The policy shall include specific procedures governing supervision of the indoor and outdoor play spaces that describe the child:staff ratio, precautions to be followed for specific areas and equipment, and staff assignments for high-risk areas.

The supervision policies of centers and large family child-care homes shall be written policies.*[Editor's Note: See also ST3 Child:Staff Ratios During Transportation, CFOC, p. 3.]*

ST4

The following child:staff ratios shall apply while children are wading or swimming:

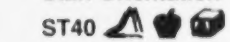
Similar Developmental Level	*Children*	*Adults*
Infants	1	1
Toddlers	2	1
Preschoolers	4	1
School-age children	6	1

*Mixed Developmental Level**	*Children*	*Adults*
Infants/toddlers	2	1
Infants/toddlers/preschoolers	3	1
Infants/toddlers/preschoolers/ school-age children	3	1
Infants/toddlers/school-age children	4	1
Preschoolers/school-age children	5	1

*There shall be a minimum of two adults present during any swimming/wading activity involving mixed developmental levels when two or more infants and/or toddlers are swimming or wading.

[Editor's Note: See also HP109 and HP111, Water Supervision, CFOC, p. 96.]

Staff Orientation

ST40 

All new full- and part-time staff shall be oriented to, and demonstrate knowledge of, the following items (a) through (o). The director of any center or large family child-care home shall provide this training to newly hired caregivers. Small family home caregivers shall avail themselves of orientation training offered by the licensing agency, a resource and referral agency, or other such agency. This training shall include evaluation and a repeat demonstration of the training lesson. The orientation shall address, at a minimum:

(a) The goals and philosophy of the facility.
(b) The names and ages of the children for whom the caregiver will be responsible, and their specific developmental needs.
(c) Any special adaptation(s) of the facility required for a child with special needs.
(d) Any special health or nutrition need(s) of the children assigned to the caregiver.
(e) The planned program of activities at the facility.
(f) Routines and transitions.
(g) Acceptable methods of discipline.
(h) Policies of the facility about relating to parents.
(i) Meal patterns and food-handling policies of the facility.
(j) Occupational health hazards for caregivers.
(k) Emergency health and safety procedures.
(l) General health policies and procedures, including but not limited to the following:
    (1) Handwashing techniques, including indications for handwashing. *[Editor's Note: HP29-32 Handwashing, CFOC, pp. 72-73.]*
    (2) Diapering technique and toileting, if care is provided to children in diapers and/or needing help with toileting, including appropriate diaper disposal and diaper-changing techniques.
    (3) Correct food preparation, serving, and storage techniques if employee prepares food.

(4) Formula preparation, if formula is handled.

(m) Child abuse detection, prevention, and reporting.

(n) Teaching health promotion concepts to children and parents as part of the daily care provided to children.

(o) Recognizing symptoms of illness.

ST62

A short-term substitute caregiver in a small family child-care home shall be oriented to emergency response practices, including how to call for emergency medical assistance, how to reach parents or emergency contacts, how to arrange for transfer to medical care, and the evacuation plan. A regularly used substitute shall have the same clearances as the small family child-care home caregiver.

[Editor's Note: Detailed information to be included in orientation and training is found in the following sections of CFOC:

PR1-57 Program of Developmental Activities, pp. 45-52
PR31-37 Discipline, pp. 52-55
PR38-53 Parent Relationships, pp. 55-60
AD45-47 Nutrition Plan and Policy, pp 284-285
AD86 Food Service Records, p. 295
NU1-108 Nutrition and Food Service, pp.115-137
ST78-79 Occupational Hazards, pp. 38-39
AD29-30 Emergency Plan, p. 280
HP105-108 Emergency Procedures, pp. 95-96
HP29-32 Handwashing, pp. 72-73
FA140-168 Toileting, Diapering, and Bath, pp. 168-173
HP13-28 Toileting, Diapering, and Toilet Training, pp. 68-72
HP40-45 Sanitation of Toilet Training Equipment, pp. 76-77
NU68-94 Food Safety, pp.130-132
NU45-47 Nutrition Plan & Policy, pp. 284-285
NU8-20 Nutrition for Infants, pp.117-120
HP94-104 Child Abuse and Neglect, pp. 93-95
PR54-59 Health Education for Children pp. 60-61
HP1-4 Daily Health Assessment, pp. 65-66]

Bloodborne Pathogens

ID48

All facility staff shall receive regular training on prevention of transmission of bloodborne diseases.

[Editor's Note: See Universal Precautions, p 43 of this document.]

ID58

Caregivers shall be knowledgeable about routes of HIV and hepatitis B transmission and about prevention of transmission.

Staff Training/First Aid and CPR

ST44

The director of a center or a large family child-care home shall ensure that all staff involved in the provision of direct care are certified in pediatric first aid that includes rescue breathing and first aid for choking. At least one certified staff person shall be in attendance at all times and in all places that children are in care.

ST45

Small family home caregivers should be certified in pediatric first aid training that includes rescue breathing and first aid for choking.

ST46

Pediatric first aid training, including rescue breathing and first aid for choking, shall be consistent with pediatric first aid training developed by the American Red Cross, the American Heart Association, or the National Safety Council for First Aid Training Institute, or the equivalent of one of the three. The offered first aid instruction shall include, but not be limited to, the emergency management of:

(a) Bleeding
(b) Burns
(c) Poisoning
(d) Choking
(e) Injuries, including insect, animal, and human bites
(f) Shock
(g) Convulsions or nonconvulsive seizures
(h) Musculoskeletal injury (i.e., sprains, fractures)
(i) Dental emergencies
(j) Head injuries
(k) Allergic reactions
(l) Eye injuries
(m) Loss of consciousness
(n) Electric shock
(o) Drowning

ST47

Facilities that have a swimming pool or built-in wading pool shall require infant and child CPR training for caregivers. At least one of the caregivers, volunteers, and other adults who are counted in the child:staff ratio for wading and swimming shall be trained in basic water safety and certified in infant and child CPR each year by a person certified as an instructor in water safety and in CPR. (For small family-child-care homes, the person trained in water safety and CPR shall be the caregiver.) Written verification of CPR and lifesaving certification, water safety instructions, and emergency procedures shall be kept on file.

ST48

Facilities that serve children with special needs shall have at least one caregiver certified in infant and child CPR. Written verification of CPR certification shall be kept on file *[Editors Note: children with special health needs who may require cardiac resuscitation]*

CSN52

All drivers, passenger monitors, and assistants involved in transportation of children with special needs shall be certified in infant/child CPR, as specified in First Aid and CPR *[Editor's Note: See ST42-48 First Aid and CPR, CFOC, pp. 22-24.]*

Staff Qualifications and Education

ST12

Caregivers shall have knowledge of child development and early childhood education; an undergraduate degree in early childhood education, child development, social work, nursing, or other child-related field, or a combination of experience under qualified supervision and college coursework; 1 year's experience or the equivalent as specified in Appendix A; and on-the-job training to provide a nurturing environment and to meet the child's out-of-home needs.

[Editor's Note. See Appendix A Qualifications and Responsibilities of Caregivers by Age groups of Children, CFOC, pp. 323-327.]

Staff Health

ST78

The center's written personnel policies shall address the major occupational health hazards for child care outlined in Appendix D.

[Editor's note: See Appendix D Occupational Hazards, CFOC. p. 337; see also ST79 Stress, CFOC, pp. 38-39. The major occupational hazards in child care are as follows:

(a) Infectious diseases: hepatitis, cytomegalovirus (CMV), chicken pox, rubella, polio, influenza, tuberculosis, shigellosis, giardia, meningitis, streptococcus, ringworm, scabies, lice, herpes, cryptosporidium, rotavirus.

(b) Injuries and noninfectious diseases: back injuries, bites, dermatitis.

(c) Stress: undervaluing of work (in both monetary compensation and status), inadequate break time, sick leave and personal days, working alone; responsibility for children's welfare, inadequate training; inadequate facilities, fear of liability.

(d) Environmental exposure: art materials, formaldehyde (indoor air pollution), noise, disinfecting solutions.

ID38

Facilities that employ women of childbearing age shall educate these workers with regard to the following:

(a) The increased probability of exposure to CMV in the child care setting.

(b) The potential for fetal damage when CMV is acquired during pregnancy.

Background Check

ST32

Center directors and small and large family home caregivers shall ask applicants for all positions whether they have abused children in any way in the past. Persons who acknowledge the past abuse of children shall not be hired in centers or assist in small or large family child-care homes even when they are licensed/certified.

ST34

Directors and large family home caregivers shall check references and examine employment history before employing any staff, including substitutes, who will be alone with a child or a group of children in child care.

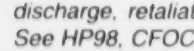
Child Abuse Recognition and Reporting

HP94

The facility shall report to the department of social services, child protective services, or police any instance where there is reasonable cause to believe that child abuse, neglect, or exploitation may have occurred.

HP97

Caregivers who report abuse in the settings where they work shall be immune from discharge, retaliation, or other disciplinary action for that reason alone, unless it is proven that the report was malicious. *[Editor's Note: Volunteers and employees in centers should also receive instructions about reporting suspected child abuse. They also shall be immune from discharge, retaliation, or other disciplinary action as a result of reporting. See HP98, CFOC, pp. 93.]*

HP101 

Center directors shall know methods for reducing the risks of child abuse. They shall know how to recognize common symptoms and signs of child abuse.

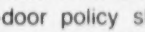
[Editor's Note: See HP99: All caregivers in all settings and at all levels of employment should know the definitions of the four forms of child abuse: emotional abuse, neglect, physical abuse, and sexual abuse, CFOC, p. 93.]

Parent Access

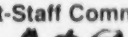
PR41

Caregivers shall inform all parents that they may visit the site at any time when their child is there, and that they will be admitted without delay. This open-door policy shall be part of the "admission agreement" or other contract between the parent and the caregiver.

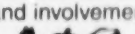
Parent-Staff Communication

PR38 

All aspects of child care programs shall be designed to facilitate parental input and involvement.

PR39 

Information about the child's daily needs and activities shall be shared with parents on a daily informal basis.

PR42 

Planned communication (e.g., parent conferences) shall be scheduled with at least one parent of every child in care to review the child's development and adjustment to care; to reach agreement on appropriate, nonviolent disciplinary measures; and to discuss specific health issues and concerns such as persistent behavior problems, developmental delays, special needs, overweight, underweight, or eating or sleeping problems. At these planned communications, the child's medical report and the health record shall be reviewed by a staff member with the parent to identify medical and developmental issues that require follow-up or adjustment of the facility. Each review shall be documented by the signature of the parent and staff reviewer in the child's facility health record. These planned communications shall be as follows:

(a) As part of the intake process.

(b) At each health update interval as follows:

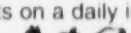
(1) Every 6 months for children under 6;

(2) Every year for children over 6.

(c) Whenever new information is added to the child's facility health record.

Notes about these planned communications shall be maintained in each child's record at the facility and shall be available for review.

[Editor's Note: See APP8 Facility Health Record, CFOC, p. 335; APP6 Medical Report, CFOC, pp. 331-332.]

PR43 

The facility shall assign a specific staff member to each parent to ensure contact between the designated staff member and parent that may take place at the beginning and end of the day or when a parent can drop in. The contact shall consist of:

(a) Discussions between the parent and staff member regarding observations about the child.

(b) Providing an opportunity for the parents to observe the child's playmates and surroundings.

PR48

Parental participation in the process of evaluating the child and making decisions about services shall be required by the facility and shall be documented. Parents shall be explicitly invited to participate in all such decision-making activities and their presence at these meetings, or invitations to attend, shall be documented in writing.

PR51

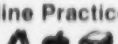
The facility shall ask parents to share with a caregiver information regarding the child's health status, especially information about the child's health since the last attendance in the facility.

CSN10

Parental participation shall include caregivers' learning about parental expectations and goals and integrating this information into the Individual Family Service Plan (IFSP).

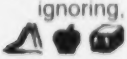
[Editor's Note: See CSN15-20 Developing a Service Plan for a Child with Special Needs, CFOC, pp. 243-245.]

Discipline Practices/Corporal Punishment

PR35 

The following behaviors shall be prohibited in all child care settings and by all caregivers:

(a) Corporal punishment, including hitting, spanking, beating, shaking, pinching, and other measures that produce physical pain.
(b) Withdrawal or the threat of withdrawal of food, rest, or bathroom opportunities.
(c) Abusive or profane language.
(d) Any form of public or private humiliation, including threats of physical punishment.
(e) Any form of emotional abuse, including rejecting, terrorizing, ignoring, isolating, or corrupting a child.

AD12 

The caregiver shall implement a policy that prohibits corporal punishment, emotional abuse, humiliation, abusive language, and the withdrawal of food and other basic needs.

PR36

Children shall not be physically restrained except as necessary to ensure their own safety or that of others, and then only for as long as is necessary for control of the situation. Children shall not be given medicines or drugs that will affect their behavior except as prescribed by their health care provider and with specific written instructions from their health care provider for the use of the medicine.

AD13

The facility's discipline policy shall outline methods of guidance appropriate to the ages of the children enrolled; it shall explicitly describe positive, nonviolent, nonabusive methods for achieving discipline. All caregivers shall sign a facility agreement to implement this discipline policy.

PR31

Discipline shall include positive guidance, redirection, and the setting of clear-cut limits that foster the child's ability to become self-disciplined. Disciplinary measures shall be clear and understandable to the child, shall be consistent, and shall be explained to the child before and at the time of any disciplinary action.

NU46

Food shall not be used as a reward or punishment.

Children with Special Health Needs (CSN)

CSN42

When centers and large family child-care homes enroll children with special needs, the director shall ensure that staff members have been oriented in understanding children with special needs and in ways of working with these children in group settings.

CSN43

Caregivers in small family child-care homes who offer care for one or more children with special needs shall participate in an orientation about the child's special needs and how these needs may affect his/her developmental progression or play with other children.

CSN67

The child's medical report shall indicate whether there is a history of seizures and whether the child is currently taking medication to control the disorder.

CSN68

The staff shall be trained in and shall be prepared to utilize the procedure that must be followed when a child has a seizure. This includes proper positioning, keeping the airway open, and knowing when and whom to call for medical assistance. Telephone numbers for emergency care shall be posted as specified in item (o) in Appendix W of CFOC.

CSN69

The child's facility health record shall denote the type and frequency both of reported seizures and of those observed in the facility.

[Editor's Note: A child's history of asthma or respiratory allergies, and whether medication is necessary, should also be part of the health record.]

CSN71

A facility that enrolls children who require suctioning, oxygen, postural drainage, or catheterization on a daily basis (unless the child ten requiring catheterization can perform this function on their own) shall include a nurse as a consultant for the facility.

CSN80

When the evaluators are not part of the child care staff, a formal mechanism shall be developed for coordinating re-evaluations and program revisions (for a child with special needs). A staff member from the facility shall routinely be included in the evaluation process, team conferences, and so forth.

NU6

Dietary modifications shall be made under the direction of a trained health care provider. The caregiver shall modify and/or supplement the child's diet because of food allergies or special dietary needs only with written permission from the child's parent or legal guardian and from the child's health care provider. The caregiver shall obtain from the parent/legal guardian or the child's health care provider, a list of foods that the child can and cannot consume . Menus shall be approved by the child care nutrition specialist. Dietary modifications shall be recorded as specified in Appendix C. *[Editor's Note: CFOC, pp. 330-336.]*

Developmentally Appropriate Practices

Birth to 35 Months

PR6

Ordinarily, no child will be considered eligible for out-of-home care before 6 weeks of age.

PR7

Opportunities shall be provided for each child to develop a personal and affectionate relationship with and attachment to one or a small number of caregivers whose care for and responsiveness to the child ensure relief of distress, experiences of comfort and stimulation, and satisfaction of the need for a social partner. The caregivers shall:

(a) Hold and comfort the child who is upset;
(b) Engage in social interchanges such as smiling, talking, and touching; and
(c) Be play partners as well as protectors.

PR11

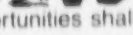
The facility shall provide space, colorful materials, and equipment, indoors and outdoors, arranged to support learning and optimize:

(a) Opportunities for the child to act upon the environment; to confront new opportunities; to experience obstacles, frustrations, and dangers; and thereby to learn to manage inner feelings and resources and the occurrences and demands of the outer world.
(b) Opportunities for play that serve to reduce anxiety and to help the child adapt to reality, resolve conflicts, bind together the inner and outer worlds, and construct systems of symbols.

3 to 5 Years

PR14

Opportunities shall be provided for children to observe, explore, order and reorder, make mistakes and find solutions, and move from the concrete to the abstract in learning.

PR17 

A cooperative rather than a competitive atmosphere shall be fostered. There shall be encouragement of verbal skills and attentiveness to the needs of individuals and the group as a whole.

ST17

Caregivers shall demonstrate an ability to apply their understanding of the developmental characteristics of 3- to 5-year-olds. Caregivers shall demonstrate knowledge and understanding of these children's independence and social competence, more complex inner lives, and increasing ability to adapt to their environment and cope with stress.

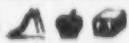
Developmentally Appropriate Nutrition Practices

NU11

Infants shall be either held or fed sitting up for bottle feeding. Infants unable to sit shall always be held for bottle feeding. Bottle propping and carrying of bottles by young children throughout the day and/or night shall not be permitted.

NU13

Only cleaned and disinfected bottles and nipples shall be used. All filled bottles of breast milk or iron-fortified formula shall be refrigerated until immediately before feeding. Any contents remaining after a feeding shall be discarded. Prepared bottles of formula from powder or concentrate or ready-to-feed formula shall be refrigerated, and shall be discarded after 24 hours if not used. An open container of ready-to-feed or concentrated formula shall be covered, refrigerated, and discarded after 48 hours if not used. Unused expressed breast milk shall be discarded after 48 hours if refrigerated, or after 2 weeks if frozen.

NU14 

Bottles of breast milk and formula shall be dated. When there is more than one bottle-fed infant, all bottles shall be labeled with the child's name. All formula and breast milk shall be used only for the intended child.

NU16

If breast milk or formula is to be warmed, bottles shall be placed in a pan of hot (not boiling) water for 5 minutes, after which the bottle shall be shaken well and the milk temperature tested before feeding. Bottles of formula or breast milk shall never be warmed in a microwave oven.

NU42

For infants, foods shall be cut up in small pieces no larger than 1/4 inch cubes.

APP24

Written policies about infant feeding shall be developed with the input and approval of the child's health care provider and the child care nutrition specialist and shall include the following:

(a) Storage and handling of expressed breast milk.
(b) Determination of the kind and amount of commercially prepared formula to be prepared for infants.
(c) Preparation, storage, and handling of formula.
(d) Use and proper disinfecting of feeding chairs and of mechanical food preparation and feeding devices, including blenders, feeding bottles, and food warmers.
(e) Whether formula or baby food shall be provided from home, and if so, how such food will be transported, stored, and handled.
(f) A prohibition against bottle propping or prolonged feeding.
(g) A prohibition against allowing children to have their bottles at times other than when they are held or while seated for feeding.
(h) Specification of the number of children who can be fed by one adult at one time.
(i) Handling of food intolerance or allergies (e.g., cow's milk, orange juice, eggs, wheat).
(j) Responding to infants' need for food in a flexible fashion to approximate demand feedings.

[Editor's Note: See Appendix J Food Components for Infants, CFOC, p. 352; Appendix B-2 Nutrition Specialist, CFOC, p. 329.]

NU40

Midinfancy children just learning to feed themselves shall be supervised by an adult who is seated at the same table or adjacent to the child's feeding chair.

NU41

Foods that are round, hard, small, thick and sticky, smooth, or slippery shall not be offered to children under 4 years of age. Examples of such foods include hot dogs (sliced into rounds), whole grapes, hard candy, nuts, seeds, raw peas, dried fruit, pretzels, chips, peanuts, popcorn, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole.

NU43

For toddlers, foods shall be cut up in small pieces no larger than 1/2 inch cubes.

[Editor's Note: See Appendix K Food Components for Toddlers, Preschoolers, CFOC, p. 353.]

NU45

A child shall be encouraged, but not forced, to eat.

[Editor's Note: Information concerning infants' and children's eating patterns will be shared with their families.]

Health Consultant

ST63

Each center and organized small family child-care home system shall utilize the services of a health consultant. Large and small family home caregivers shall avail themselves of community resources established for health consultation to child care.

ST64

The health consultant shall be a physician, certified pediatric or family nurse practitioner, or registered nurse with pediatric or out-of-home child care experience, and shall be knowledgeable about out-of-home child care, community child care licensing requirements, and available health resources.

ST65

The health consultant shall visit each facility regularly to review and give advice on the facility's health component. Facilities that serve any child under 2 years of age shall be visited at least once a month. Facilities that are now open every day or that serve only children 2 years of age or older shall be visited quarterly on a schedule that meets the needs of the composite group of children.

Medication Administration and Storage

HP82

The administration of medicines at the facility shall be limited to:

(a) Prescribed medications ordered by a health care provider for a specific child.

(b) Nonprescription medications recommended by a health care provider for a specific child, with written permission of the parent or legal guardian referencing a written or telephone instruction received by the facility from the health care provider.

HP83

Any prescribed medication brought into the facility by the parent, legal guardian, or responsible relative of a child shall be dated, and shall be kept in the original container labeled by a pharmacist with the child's first and last names; the date the prescription was filled; the name of the health care provider who wrote the prescription; the medication's expiration date; and specific, legible instructions for administration, storage, and disposal (i.e., the manufacturer's instructions or prescription label).

HP84

Any over-the-counter medication brought into the facility for use by a specific child shall be labeled with the following information: the date; the child's first and last names; specific, legible instructions for administration and storage (i.e. the manufacturer's instructions); and the name of the health care provider who made the recommendation.

HP85

All medications, refrigerated or unrefrigerated, shall have child-protective caps, shall be kept in an orderly fashion, shall be stored away from food at the proper temperature, and shall be inaccessible to children. Medication shall not be used beyond the date of expiration.

HP87

Any caregiver who administers medication *[Editor's note: including over-the counter medication]* shall be trained to check for the name of the child; to read the label/prescription directions in relation to the measured dose, frequency, and other circumstances relative to administration (e.g., relation to meals); and to document properly that the medication was administered.

APP7 *(Appendix C, CFOC)*

A medication record maintained on an ongoing basis by designated staff shall include the following:

(1) Specific, signed parent consent for the caregiver to administer medication;
(2) Prescription by a health care provider, if required;
(3) Administration log;
(4) Checklist information on medication brought to the facility by the parents.

[Editor's Note: CFOC, p. 335.]

Records/Files

APP4 *(Appendix C, CFOC)*

The facility shall maintain a file for each child in one central location within the facility. This file shall be kept in a confidential manner, but shall be immediately available to the child's caregiver, parents, or legal guardians, and the licensing authority upon request.

APP5 *(Appendix C, FCFOC)*

The file for each child (see standard APP4) shall include the following:

(A) Pre-admission enrollment information including the following:
  (1) The child's name, address, sex, and date of birth.
  (2) The full names of the child's parents or legal guardians, and their home and work addresses and telephone numbers. Telephone contact numbers shall be confirmed by a call placed by the facility during its hours of operation. Names, addresses, and telephone numbers shall be updated at least quarterly.
  (3) The names, addresses, and telephone numbers of at least two additional persons to be notified in the event that the parents or legal guardians cannot be located. Telephone information shall be confirmed and updated as specified in item (2) above.
  (4) The names and telephone numbers of the child's primary sources of medical care, emergency medical care, and dental care.

(5) The child's health payment resource
[Editor's Note: or health insurance coverage.]

(6) The emergency information in items 1 through 5 above shall be obtained in duplicate with original parent/legal guardian signatures on both copies, and one copy shall be easily accessible at all times. This information shall be updated quarterly and as necessary. The duplicate card must accompany the child to all off-site excursions.

(7) Written instructions of the parent, legal guardian, or child's health care provider for any special dietary needs or special needs due to a health condition, or any other special instructions from the parent.

(8) Scheduled days and hours of attendance.

(9) In the event that one parent is the sole legal guardian of the child, legal documentation evidencing his/her authority.

(10) Enrollment date, reason for entry in child care, and fee arrangements.

(11) Signed permission to act on parent's behalf for emergency treatment and for use of syrup of ipecac.

(12) Authorization to release child to anyone other than the custodial parent.

[Editor's Note: APP4 , CFOC, p. 330.]

APP6 (Appendix C, CFOC)

(B) A *medical report* completed and signed by the child's health care provider, preferably *prior to enrollment or no later than 6 weeks after admission. [Editor's Note: italicized in original]* The medical report shall include the following medical and developmental information:

(1) Records of the child's immunizations.

(2) A description of any disability, sensory impairment, developmental variation, seizure disorder, or emotional or behavioral disturbance that may affect adaptation to child care (include previous surgery, serious illness, history of prematurity, etc., only if relevant).

(3) An assessment of the child's growth based on height, weight, and head circumference and the percentile for each, if the child is younger than 24 months.

(4) A description of health problems or findings from an examination or screening that need follow-up.

(5) Results of screenings—vision, hearing, dental, nutrition, developmental, tuberculosis, hemoglobin, urine, lead, and so forth.

(6) Dates of significant communicable diseases (e.g., chicken pox).

(7) Prescribed medication(s), including information on recognizing, documenting, and reporting potential side effects.

(8) A description of current acute or chronic health problems under or needing treatment.

(9) A description of past serious injuries that required medical attention or hospitalization.

(10) Special instructions for the caregiver.

The medical report shall include space for additional comments about the management of health problems and for additional health-related data offered by the health care provider or required from the facility.

The medical report shall be updated as follows:

- No later than 6 weeks after admission to the facility.
- Every 6 months for children under 2 years of age.
- Every year for children ages 2 to 6.
- Every 2 years for school-age children.

(C) Signed parent agreement at enrollment, including the following:

(1) Admission agreement or contract stating the rule prohibiting corporal punishment.

(2) Admission agreement or contract stating that all parents may visit the site at any time when their child is there, and that they will be admitted immediately.

(3) Documentation of written consent signed and dated by the parent or legal guardian for:

(a) Emergency transportation.

(b) All other transportation provided by the facility.

(c) Planned or unplanned activities off-premises. Such consent shall give specific information about where, when, and how such activities shall take place, including specific information about walking to and from activities away from the facility.

(d) Phone authorizations for release of the child.

(e) Swimming/wading, if the child will be participating.

(f) Any health service obtained for the child by the facility on behalf of the parent. Such consent shall be specific for the type of care provided to meet the tests for "informed consent" to cover on-site screenings or other services provided.

(g) Release of any information to agencies, schools, or providers of services.

(h) Authorization to release the child to anyone other than the custodial parent.

(i) Emergency treatment.

(j) Administration of medications.

(4) Statement that parent has received and discussed a copy of the state child abuse reporting requirements.

(D) A health history completed by the parent at admission, preferably with staff involvement. This history shall include the following:

(1) Developmental variations, sensory impairment, or a disability that may need consideration in the child care setting.
(2) Description of current physical, social and language development levels.
(3) Current medications.
(4) Special concerns—allergies, chronic illness, pediatric first aid information needs.
(5) Specific diet restrictions, if the child is on a special diet.
(6) Individual characteristics or personality factors relevant to child care.
(7) Special family considerations.
(8) Dates of communicable diseases.

AD62

Written releases shall be obtained from the child's parent or legal guardian prior to forwarding information and/or the child's records.

Confidential Information

AD61

The director of the facility shall decide who among the staff may have confidential information shared with them. Clearly, this decision must be made selectively, and all caregivers must be taught the basic principles of all individuals' rights to confidentiality.

AD64

The content of the written procedures for protecting the confidentiality of medical and social information shall be consistent with federal, state, and local guidelines and regulations and shall be taught to caregivers. Confidential medical information pertinent to safe care of the child shall be provided to facilities within the guidelines of state or local public health regulations. However, under all circumstances, confidentiality about the child's medical condition and the family's status shall be preserved unless such information is released at the written request of the family, except in cases where abuse or neglect is a concern. In such cases, state laws and regulations apply.

Release Authorization

AD37

Names, addresses, and telephone numbers of persons authorized to take the child under care out of the facility shall be maintained. Policies shall also address how the facility will handle the situation if a parent arrives intoxicated or otherwise incapable of bringing the child home safely, or if a noncustodial parent attempts to improperly claim the child under the legal custody agreement.

INFECTION CONTROL

Handwashing

HP29

Staff and children shall wash their hands at least at the following times, and whenever hands are contaminated with body fluids:

(a) Before food preparation, handling, or serving.
(b) After toileting or changing diapers.
(c) After assisting a child with toilet use.
(d) Before handling food.
(e) Before any food service activity (including setting the table).
(f) Before and after eating meals or snacks.
(g) After handling pets or other animals.

HP30

Children and staff members shall wash their hands for at least 10 seconds with soap and warm running water.

ID32

Caregivers shall be instructed in the importance of handwashing and other measures aimed at limiting the transfer of infected material (e.g., saliva, tissue fluid, or fluid from a skin sore).

HP36

Handwashing after exposure to blood or blood-containing body fluids and tissue discharges as specified in HP72 Handwashing, shall be observed.

HP133

A handwashing sink shall be present in each child care room. (See FA69.)

FA69

When plumbing is unavailable to provide a handwashing sink (see sinks, CFOC, p170), the facility shall provide a handwashing sink using a portable water supply and a sanitary catch system approved by a local sanitarian.

HP34

Noses shall be blown or wiped with disposable, one-use tissues that are discarded in a plastic-lined and covered garbage container. Hands shall be washed after blowing as specified in Handwashing.

Diapering/Diapering Areas

HP13

Diapers worn by children shall be able to contain urine and stool and minimize fecal contamination of the children, caregivers, environmental surfaces, and objects of the child care setting. The diaper shall have an absorbent inner lining completely contained within an outer covering made of waterproof material that prevents the escape of feces and urine. The outer covering and inner lining shall be changed together at the same time as a unit and shall not be reused unless both are cleaned and disinfected.
[Editor's Note: See also HP 19 for standards on cloth diapers and, by extension, training pants. CFOC, p. 70.]

HP15

Diaper changing procedures consistent with those recommended by the Centers for Disease Control in the publication *What to Do to Stop Disease* in *Child Day Care Centers* shall be posted in the changing area.

[Editor's Note: The above publication is being revised by the Centers for Disease Control and Prevention. For more information please contact: Centers for Disease Control and Prevention, 1600 Clifton Road, N.E., Atlanta, GA 30333.]

HP134

Each room in which children who wear diapers are cared for shall have its own diaper-changing area placed adjacent to the handwashing sink.

FA80

Soiled diapers shall be stored in containers separate from other waste. Conveniently located, washable, plastic-lined, tightly covered receptacles, operated by a foot-pedal, shall be provided within arm's reach of diaper-changing tables for soiled diapers. Separate containers shall be used for disposable diapers, cloth diapers (if used), and soiled clothes and linens.

FA81

Each waste and diaper container shall be labeled and kept clean and free of build-up of soil and odor. Waste water from such cleaning operations shall be disposed of as sewage.

FA154

The changing area shall never be located in food preparation areas and shall never be used for temporary placement or serving of food.

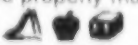
Food Safety/Sanitation

NU50

The food preparation area of the kitchen shall be separate from the eating, play, toilet, and bathroom areas and from areas where animals are kept, and shall not be used as a passageway while food is being prepared. Food preparation areas shall be separated from areas used by the children for activities unrelated to food by a door, gate, counter, or room divider except in small family-child-care homes when separation may limit child supervision.

NU52

All kitchen equipment shall be clean and in good operable condition and shall be properly maintained.

NU69 

No one who has signs or symptoms of illness, including vomiting, diarrhea, and infectious skin sores that cannot be covered, or who is potentially or actually infected with bacteria or viruses that can be carried in food, shall be responsible for food handling. No one with open or infected injuries shall work in the food preparation area unless the injuries are covered with nonporous (e.g., latex) gloves.

51

NU77

Home-canned food, food from dented, rusted, bulging, or leaking cans, and food from cans without labels shall not be used.

NU75

Raw, unpasteurized milk or milk products shall not be used.

NU80

Meat, fish, poultry, milk, and egg products shall be refrigerated until immediately before use.

NU70

Staff members who prepare food shall not change diapers. Staff members who work with diapered children shall not prepare or serve food for older groups of children. When it is not possible to observe these restrictions, staff members who are responsible for changing diapers shall prepare or serve food to the infants and toddlers in their groups only after thoroughly washing their hands. Caregivers who prepare food for infants shall practice careful handwashing before handling food, including infant bottles of formula or breast milk.

Reporting

HP78

Each facility shall, upon registration of each child, inform parents of the need to notify the facility within 24 hours after the child has developed a known or suspected communicable disease, or if any member of the immediate household has a communicable disease, and to inform the facility of any other illness that is not a communicable disease or other absence experienced by the child when the child returns to the facility. When the child has a disease requiring exclusion or dismissal, the parents shall inform the facility of the diagnosis.

HP80

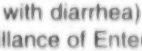
The facility shall comply with the state's reporting requirements for ill children. All *[Editor's note: reportable]* communicable diseases shall be reported to the public health agency.

Gastrointestinal Infection

AD16

Policies shall be used to prevent and control infections of the intestines (often with diarrhea) or liver and diarrhea diseases as specified in Disease Surveillance of Enteric (Diarrhea) and Hepatitis A Virus Infection.

[Editor's Note: See ID25-26 CFOC, p. 218.]

ID22 

If there has been an exposure to hepatitis A, parents of other children who attend the facility shall be informed, in cooperation with the local health department, that their child may have been exposed to the virus and may be at increased risk of developing hepatitis A. Guidelines on the administration of immune globulin given to prevent an infection in contacts of children with hepatitis A disease shall be implemented also in cooperation with the local health department.

[Editor's note: Hepatitis A vaccine is now available, although Hepatitis A vaccine isn't recommended routinely for child care staff at this time.]

Meningococcal Disease

APP19

Local health departments shall develop specific guidelines for responding to the occurrence of a case of meningococcal disease in a child who attends child care. These guidelines shall include a position on the use of the antibiotic to be taken to prevent an infection in child contacts of children with meningococcal disease. These guidelines shall be consistent with the most current recommendations of the American Academy of Pediatrics (AAP) and the U.S. Public Health Service Advisory Committee on Immunization Practices.

[Editor's note: This standard has been edited to reflect information found in "Meningococcal Disease Prevention and Control Strategies for Practice-based Physicians", American Academy of Pediatrics, Pediatrics, 97 (3), March 1996.

(a) Careful observation of child care contacts of children with meningococcal disease is essential, especially in young children. Children who develop illnesses with fever shall receive rapid medical evaluation.

(b) Child care contacts (children of all ages and adults) shall receive the antibiotic to prevent an infection as soon as possible, preferably within 24 hours after diagnosis of the primary case.

(c) Child care contacts (children and adults) shall be excluded from attending the facility until the antibiotic taken to prevent an infection has been initiated.

(d) When child care exposure to meningococcal disease has occurred, representatives of the local health department shall supervise the administration of the antibiotic to be taken to prevent an infection.

e) The local public health authorities shall be consulted to determine whether vaccination is appropriate.]

Hib Infection

APP11

The local health department shall be informed within 24 hours of the occurrence of a serious Hib infection (e.g., an infection associated with bacteremia or meningitis) by the physician who diagnosed the illness, in accordance with local and state health department rules for reportable diseases. The report to the health department shall specify whether the child attends a child care facility.

APP12

The local health department shall inform the director of the ill child's facility that an attendee has a serious Hib infection.

APP13

When recommended by the responsible health department to present secondary Hib disease in the facility, rifampin shall be administered orally in a dose of 20 mg per kg body weight (maximum dose 600 mg) given once daily for 4 consecutive days.

(a) The dose for adults is 600 mg given orally as a single dose on 4 consecutive days.

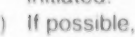
(b) Pregnant women shall not receive the antibiotic to prevent an infection because rifampin is contraindicated during pregnancy.

(c) When an antibiotic is indicated for child care contacts to prevent an infection, children and staff shall be excluded from attending the facility until the antibiotic to prevent an infection has been initiated.

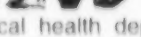
(d) If possible, health department representatives shall supervise the administration of rifampin to all child contacts in the facility. This supervision ensures that the same policy described in Appendix I-1 will be followed by all attendees and that the disease-prevention measure will be administered to all contacts simultaneously.

[Editor's Note: APP11-14 Recommended Practices for Haemophilus Influenzae Type B, CFOC, pp. 343-345.]

Pertussis

APP20 

The local health department shall be informed within 24 hours of the occurrence of a case of pertussis by the physician who diagnosed the illness, in accordance with local and state health department rules for reportable diseases. The report to the health department shall specify whether the child attends a facility.

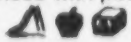
APP21 

The local health department shall inform the director of the ill child's facility that an attendee has pertussis.

Tuberculosis (TB)

ID1

Tuberculosis (TB) infection shall be controlled by requiring staff members to have their TB status assessed prior to beginning employment. Persons with positive screening skin test *[Editor's Note: tine test]* reactions shall be evaluated with the intradermal PPD (5TU) skin test followed by chest x-rays for those with positive PPD reactions (10+ mm induration).

ID2 

Tuberculosis screening by skin testing of staff members with previously negative skin tests shall be repeated systematically (at least every 2 years or as dictated by the state or local health department). Staff members with previously positive skin tests shall be under management of a physician.
[Editor's Note: See HP151 III Child Exclusion, re: guidance on other infectious diseases.]

Special Considerations for HIV-Infected Children and Staff

ID60

Parents of an HIV-infected child shall be notified immediately if the child has been exposed to chicken pox, TB, or measles through other children in the facility.

ID61

A child whose immune system does not function properly to prevent infection and who is exposed to measles or chicken pox shall be referred immediately to his/her health care provider to receive the appropriate preventive measure (immune globulin) following exposure.

ID63

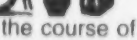
Caregivers known to be HIV-infected shall be notified immediately if they have been exposed to chicken pox, TB, or measles through children in the facility; they shall receive an appropriate preventive measure (immune globulin) after exposure if exposed to measles or chicken pox; and their return to work after exposure shall be determined jointly by the center director or large or small family home caregiver and the health care provider for the HIV-infected caregiver.

Drop-in Care

AD91

Facilities that provide drop-in care shall comply with all of the APHA/AAP Standards except those in Health Plan, and Records. In addition, at the time of enrollment, parents shall provide evidence that the child is up to date with recommended immunizations as specified in Vaccine-Preventable Diseases.
[Editor's Note: AD19-28 Health Plan, CFOC, pp. 276-279; AD57-88 Records, CFOC, pp. 287-296; ID27-30 Vaccine Preventable Diseases, CFOC, pp. 219-221.]

Ill Child/Exclusion

HP71 

During the course of an identified outbreak of any communicable illness at the facility, a child shall be excluded if the local health official determines that the child is contributing to the transmission of the illness at the facility. The child shall be readmitted when the local health official or health care provider who made the initial determination decides that the risk of transmission is no longer present.

HP151

Inclusion and exclusion policies shall be considered by facilities that care for ill children for conditions requiring extra attention from the caregiver.

(a) Ill children may be included in a special facility if they have symptoms and signs of illness that exclude them from a regular well-child facility.

(b) Ill children with any of the following signs and symptoms shall be excluded from care in the facility for ill children:

(1) Fever with stiff neck, lethargy, irritability, or persistent crying.

(2) Diarrhea (i.e., five or more stools in an 8-hour period or an increased number of stools compared to the child's normal pattern, and with increased stool water and/or decreased form) in addition to one or more of the following:

(a) Signs of dehydration.

(b) Blood or mucus in the stool, unless one stool culture demonstrates absence of shigella, salmonella, campylobacter, and E.coli 015:H57.

(3) Diarrhea due to shigella, salmonella, campylobacter, or giardia. However, a child with diarrhea due to shigella, salmonella, or giardia may be readmitted 24 hours after treatment has been initiated if cleared by his/her physician.

(4) Vomiting three or more times, or with signs of dehydration.

(5) Contagious stages of pertussis, measles, mumps, chicken pox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness.

(6) Untreated infestation (i.e., scabies, head lice).

(7) Untreated tuberculosis.

(8) Undiagnosed rash.

(9) Abdominal pain that is intermittent or persistent.

(10) Difficulty in breathing.

(11) Lethargy such that the child does not play.

(12) Other conditions as may be determined by the director or health consultant on an individual basis.

AD15

The facility's plan for the care of ill children and caregivers shall include the following. Centers and large family child-care homes shall have written policies for the care of ill children and caregivers.

(a) Standing orders for emergency care.

(b) Admission and inclusion/exclusion policies. Conditions that require that a child be excluded and sent home are specified in Child Inclusion/Exclusion/Dismissal.

(c) A description of illnesses common to children in child care, their management, and precautions to protect the health of other children and caregivers.

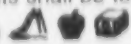
(d) A procedure for documenting the date and time of illness, the person affected, a description of symptoms, the response of the caregiver to these symptoms, who was notified (e.g., parent, legal guardian, nurse, physician, health departments), and their response.

(e) The standards described in Reporting Illness, and Notification of Parents.

[Editor's Note: See HP68-72 Child Inclusion/Exclusion/Dismissal, CFOC, pp. 80-84; HP78-81 Reporting Illness, CFOC, pp. 87-88; HP88-92 Notification of Parents, CFOC, pp. 90-92; see also HP73-74 Staff Exclusion, CFOC, pp. 84-86.]

HP91

For the child with persistent abdominal pain (continues for more than 2 hours) or intermittent pain associated with fever or other symptoms, the parents shall be told to obtain medical consultation.

HP90 

If a child has diarrhea with blood or mucus in diarrhea stool(s), the parents shall be told to have the child seen by a health care provider.

Immunizations and Preventive Health Services

AD23

Prior to admission to the facility, the facility shall require that the parent or legal guardian provide documentation that the child has received immunizations and health supervision to correct any omissions in immunizations and/or health assessments, based on the AAP's [American Academy of Pediatrics] recommended schedule.

APP26

The following immunization schedule, or a similar schedule as may be modified in the future by the Advisory Committee on Immunization Practices (ACIP) of the US. Public Health Service and the American Academy of Pediatrics (AAP), or as may be modified by local health departments to control disease outbreaks (e.g., measles vaccine at 6 months of age in outbreak control), shall be used routinely for all infants beginning at the age of 2 months. *[Editor's Note: Current Immunization schedule now begins at an earlier age. See Appendix A for updated immunization schedule.]*

APP27

The following immunization schedule, or a similar schedule as may be modified in the future by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Pediatrics (AAP), shall be used routinely for all children younger than 7 years who were not immunized at the recommended time in infant:
[Editor's note: See Appendix A for updated immunization schedule.]

HP77

Infants and children, including infants and children who were not immunized at the recommended time in early infancy, shall be immunized as specified in Vaccine-Preventable Diseases. *[Editor's Note: See ID27-31 Vaccine-Preventable Diseases, CFOC, pp. 219-221.]*

AD21

There shall be written policies and procedures that comply with local and state regulations for filing and regularly updating each child's immunization record, according to the recommended schedule, prior to admission. A child's immunizations shall be up to date for age on admission or shall be initiated before admission and updated according to the recommended schedule after admission.

HP75

If immunizations are contraindicated because of a medical condition, a statement from the child's health care provider shall be on file. This standard also applies to school-age child care facilities.

ST73

Staff shall be current for immunizations (as specified in standard ID31).
[Editor's note: See current information in Appendix A; see also ID27-31 Vaccine-Preventable Diseases, CFOC, pp. 219-221.]

Universal Precautions

ID52

Caregivers shall adopt universal precautions as outlined in Prevention of Exposure to Blood.*[Editor's Note: See 35-38 Prevention of Exposure to Blood CFOC, pp. 74-76.]*

HP38

Spills of body fluids (i.e., urine, feces, blood, saliva, nasal discharge, eye discharge, and injury or tissue discharges) shall be cleaned up immediately, as follows:

(a) For spills of vomit, urine, and feces: walls, bathrooms, table tops, toys, kitchen counter-tops, and diaper-changing tables shall be cleaned and disinfected
[Editor's Note: See definitions of Clean and of Disinfect in Glossary]

(b) For spills of blood or blood-containing body fluids and injury tissue discharges, the area shall be cleaned and disinfected. Gloves shall be used in these situations unless the amount of blood or body fluid is so small that it can easily be contained by the material used for cleaning. [Editor's Note: If disposable gloves are used, they must be discarded immediately and hands washed, HP26, CFOC, p. 71.].

(c) Persons involved in cleaning contaminated surfaces shall avoid exposure of open skin sores or mucous membranes to blood or blood-containing body fluids and injury or tissue discharges by using gloves to protect hands when cleaning contaminated surfaces.

(d) Mops shall be cleaned, rinsed in sanitizing solution, and then wrung as dry as possible and hung to dry.
[Editor's Note: See HP63, CFOC, p. 80.]

(e) Blood-contaminated material and diapers shall be disposed of in a plastic bag with a secure tie.
[Editor's Note: See Standards HP29, HP30, ID32, HP36, HP133, FA69 and HP34, pp 35 of this document.]

GLOSSARY

Note Many of the items in this glossary are reprinted with permission from Infectious Diseases in Child Care Settings: Information for Directors, Caregivers, and Parents or Guardians, prepared by the Epidemiology Departments of Hennepin County Community Health, St. Paul Division of Public Health, Minnesota Department of Health, Washington County Public Health, and Bloomington Division of Health.

AAP - Abbreviation for the American Academy of Pediatrics, a national organization of pediatricians founded in 1930 and dedicated to the improvement of child health and welfare.

ACIP - Abbreviation for the U.S. Public Health Service Advisory Committee on Immunization Practices, which provides general recommendations on immunization against certain communicable diseases.

AIDS - *See* Human immunodeficiency virus (HIV) disease.

ANSI - Abbreviation for the American National Standards Institute, an organization that acts as a clearinghouse for standards, ensuring that any standard that comes out is created by a consensus process.

APHA - Abbreviation for the American Public Health Association, a national organization of health professionals, which protects and promotes the health of the public through education, research, advocacy, and policy development.

ASTM - Abbreviation for the American Society for Testing and Materials, an organization that provides voluntary standards through a consensus process for materials, products, systems, and services.

Bacteria - (Plural of bacterium.) Organisms with a cell wall that can survive in and out of the body. They are much larger than viruses and usually can be treated effectively with antibiotics.

Bleach solution for disinfecting environmental surfaces - One quarter (1/4) cup of household liquid chlorine bleach (sodium hypochloride) in 1 gallon of water, prepared fresh daily. *See also* Disinfect.

Body fluids - Urine, feces, saliva, blood, nasal discharge, eye discharge, and injury or tissue discharge.

Bronchitis - An inflammation or swelling of the tubes leading into the lungs, often caused by a bacterial or viral infection.

Campylobacteriosis - A diarrheal infection caused by the campylobacter bacterium.

Cardiopulmonary resuscitation (CPR) - Emergency measures performed by a person on another person whose breathing or heart activity has stopped. Procedures include closed chest cardiac compressions and mouth-to-mouth ventilation in a regular sequence.

Caregiver - Used here to indicate the primary staff member who works directly with the children, that is, director, teacher, aide, or others in the center, and the child care provider in small and large family child care homes.

Catheterization - The process of inserting a hollow tube into an organ of the body, either for an investigative purpose or to give some form of treatment (e.g., to remove urine from the bladder of a child with neurologic disease).

CDC - Abbreviation for the Centers for Disease Control and Prevention, which is responsible for monitoring communicable diseases, immunization status, and congenital malformations, and for performing other disease surveillance activities in the United States.

Center - A facility that provides care and education for any number of children in a nonresidential setting and is open on a regular basis (i.e., not a drop-in facility).

Child abuse - For the purposes of this set of standards, its definition is considered to be that contained in the laws of the state in which the standards will be applied. Although these differ somewhat, most of them contain basic elements as follows:

> **Emotional abuse** - Acts that damage a child in psychological ways, but do not fall into other categories of abuse. Most states require for prosecution that psychological damage be very definite and clearly diagnosed by a psychologist or psychiatrist; this category of abuse is rarely reported and even more rarely a cause of protective action.

General neglect - Failure to provide the common necessities, including food, shelter, a safe environment, education, and health care, but without resultant or likely harm to the child.

Severe neglect - Neglect that results or is likely to result in harm to the child.

Physical abuse - An intentional (nonaccidental) act affecting a child that produces tangible physical harm.

Sexual abuse - Any sexual act performed with a child by an adult or by another child who exerts control over the victim. (Many state laws provide considerable detail about the specific acts that constitute sexual abuse.)

Child:staff ratio - The maximum number of children permitted per caregiver.

Children with special needs - Children with developmental disabilities, mental retardation, emotional disturbance, sensory or motor impairment, or significant chronic illness who require special health surveillance or specialized programs, interventions, technologies, or facilities.

Clean - To remove dirt and debris (e.g., blood, urine, and feces) by scrubbing and washing with soap and water.

CMV - See Cytomegalovirus.

Communicable disease - A disease caused by a microorganism (bacterium, virus, fungus, or parasite) that can be transmitted from person to person via an infected body fluid or respiratory spray, with or without an intermediary agent (e.g., louse, mosquito) or environmental object (e.g., table surface).

Conjunctivitis (pink eye) - Inflammation (redness and swelling) of the delicate tissue that covers the inside of the eyelids and the eyeball.

Contamination - The presence of infectious microorganisms in or on the body, on environmental surfaces, on articles of clothing, or in food or water.

Corporal punishment - Pain or suffering inflicted on the body (e.g., spanking).

CPR - See Cardiopulmonary resuscitation.

CPSC - Abbreviation for the U.S. Consumer Product Safety Commission, created in 1972 and charged with the following responsibilities:

(1) to protect the public against unreasonable risks of injury associated with consumer products;

(2) to assist consumers in evaluating the comparative safety of consumer products;

(3) to develop uniform safety standards for consumer products and to minimize conflicting state and local regulations; and

(4) to promote research and investigation into the causes and prevention of product related deaths, illnesses, and injuries.

Cryptosporidiosis - A diarrheal illness caused by the parasite cryptosporidium.

Cytomegalovirus (CMV) - A common virus, that often infects young children. In most cases, CMV causes no symptoms. When symptoms are experienced, they typically consist of fever, swollen glands, and fatigue. CMV can infect a pregnant woman who is not immune and damage the fetus, leading to mental retardation, hearing loss, and other nervous system problems in the unborn child.

Dermatitis - An inflammation of the skin due to irritation or infection.

Diarrhea - An increased number of abnormally loose stools in comparison with the individual's usual bowel habits.

Diphtheria - A serious infection of the nose and throat caused by the Corynebacterium diphtheriae producing symptoms of sore throat, low fever, chills, and a grayish membrane in the throat. The membrane can make swallowing and breathing difficult and may cause suffocation. The bacteria produce a toxin (a type of poisonous substance) that can cause severe and permanent damage to the nervous system and heart.

Disinfect - To eliminate virtually all germs from inanimate surfaces through the use of chemicals (e.g., products registered with the U.S. Environmental Protection Agency as "disinfectants") or physical agents (e.g., heat). In the child care environment, a solution of 1/4 cup household liquid chlorine bleach added to 1 gallon of tap water and prepared fresh daily is an effective disinfectant for environmental surfaces and other inanimate objects that have been contaminated with body fluids (*See* Body fluids), provided that the surfaces have first been cleaned (*See* Clean) of organic material before disinfecting. To achieve maximum disinfection with bleach, the precleaned surfaces should be left moderately or glistening wet with the bleach solution and allowed to air-dry. A slight chlorine odor should emanate from this solution. If there is no chlorine smell, a new solution must be made, even if the solution was prepared fresh that day. The solution will contain 500-800 parts per million (ppm) chlorine. Solutions much less concentrated than the recommended dilution have been shown in laboratory tests to kill high numbers of bloodborne viruses, including HIV and hepatitis B virus. This solution is not toxic if accidentally ingested by a child. However, since this solution is moderately corrosive, caution should be exercised in handling it and when wetting or using it on items containing metals, especially aluminum. DO NOT MIX UNDILUTED BLEACH OR THE DILUTED BLEACH SOLUTION WITH OTHER FLUIDS, ESPECIALLY ACIDS (E.G., VINEGAR), AS THIS WILL RESULT IN THE RAPID EVOLUTION OF HIGHLY POISONOUS CHLORINE GAS. A disinfecting agent that is at least as effective as the chlorine bleach solution and is approved by the state or local health department may be used as a disinfectant in place of the bleach solution. Disinfection is commonly used for toys, children's table tops, diaper-changing tables, food utensils, and any other object or surface that is significantly contaminated with body fluids. Disinfection of food utensils can be accomplished by using a dishwasher or equivalent process, as described in Maintenance.

Drop in care - Sporadic care for less than 10 hours per week and no more than once a week.

DTP - Abbreviation for the immunization against diphtheria, tetanus and pertussis.

Emergency response practices - Procedures used to call for emergency medical assistance, to reach parents or emergency contacts, to arrange for transfer to medical assistance, and to render first aid to the injured person.

Encapsulated - Describes asbestos fibers that are coated with a material that makes them not easily inhaled.

Encephalitis - Inflammation (redness and swelling) of the brain, which can be caused by a number of viruses, including mumps, measles, and varicella.

Enteric - Describing infections of the intestines (often with diarrhea) or liver.

EPA - Abbreviation for the U.S. Environmental Protection Agency, established in 1970, which administers federal programs on air and water pollution, solid waste disposal, pesticide regulation, and radiation and noise control.

Evaluation - Impressions and recommendations formed after a careful appraisal and study resulting in impressions and recommendations.

Exclusion - Denying admission of an ill child or staff member to a facility (*See* Inclusion/Exclusion/Dismissal.)

Facility - A legal definition referring to the buildings, the funds, the equipment, and the people involved in providing child care of any type.

Fecal coliforms - Bacteria in stools that normally inhabit the gastrointestinal tract and are used as indicators of fecal pollution. They denote the presence of intestinal pathogens in water or food.

Fecal-oral-transmission - Transfer of a germ from an infected person's stool (bowel movement) into another person's mouth to infect him/her. This transmission usually occurs when the infected person fails to wash his/her hands after having a bowel movement and then handles things (e.g., food or toys) that other people subsequently put in their mouths. Many diseases are spread this way, including hepatitis A, campylobacteriosis, shigellosis, and salmonellosis.

Fever - An elevation of body temperature. The body temperature can normally be as high as 99.3 degrees oral, 101 degrees rectal, or 98 degrees axillary. A fever exists when the body temperature is higher than these numbers. The amount of temperature elevation varies at different body sites, and the height of the fever does not indicate a more or less severe illness.

The method chosen to take a child's temperature depends on the need for accuracy, available equipment skill of the person taking the temperature, and ability of the child to assist in the procedure. Oral temperatures should not be taken on children younger than 4 years. Rectal temperatures should be taken only by persons with specific health training in performing this procedure. Axillary temperatures are accurate only in young infants. (*See* Child Inclusion/Exclusion/Dismissal regarding fever criteria for inclusion/exclusion purposes.) Electronic devices for measuring temperature in the ear canal give temperature results similar to rectal temperature, but these devices require specific training and are not widely used in child care settings.

First aid

See Pediatric first aid.

Giardia lamblia - A parasite that causes giardiasis, a diarrheal illness.

Group size - The number of children assigned to a caregiver or team of caregivers occupying an individual classroom or well-defined space within a larger room. (*See* Child:Staff Ratio and Group Size.)

Haemophilus influenzae type b (Hib) - The most frequent cause of bacterial infections (i.e., meningitis, blood infections, pneumonia, arthritis) in infants and young children in the United States.

Health care provider - A health professional licensed to write prescriptions (e.g., a physician, nurse practitioner, or physician's assistant).

Health consultant - A physician, certified pediatric or family nurse practitioner, or registered nurse who has pediatric or child care experience and is knowledgeable in child care, licensing, and community resources. The health consultant provides guidance and assistance to child care staff on health aspects of the facility. (*See* Health Consultation, Consultation Records, Health Consultants, and Health Consultants)

Health plan - A written document that describes emergency health and safety procedures, general health policies and procedures, and policies covering the management of mild illness, injury prevention, and occupational health and safety.

Hepatitis - Inflammation of the liver caused by viral infection. There are five types of infectious hepatitis: type A, type B, nonA, nonB, C, and delta hepatitis. Hepatitis type A infection has been documented as a frequent cause of hepatitis in child care settings and is often asymptomatic in children. Chronic carriers of hepatitis may be found in child care settings. NonA, nonB, and C hepatitis are associated with blood transfusions and intravenous drug abuse, and have not been identified as a problem in child care settings. Delta hepatitis occasionally accompanies hepatitis B infections.

Hib-*See* Haemophilus influenzae type b.

HIV-*See* Human immunodeficiency virus disease.

Human immunodeficiency virus (HIV) - a pathogen leading to failure of the human immune system, leaving the body unable to fight infections and cancers. It is characterized by a relatively long (up to 10 years) asymptomatic stage and a brief acute stage. Gradually, an HIV-infected person develops multiple symptoms and infections that progress to the end stage of the disease, called acquired immunodeficiency syndrome (AIDS). HIV is transmitted by sexual contact or blood-to-blood contact, or from an infected mother to her baby during pregnancy, labor, delivery, or breast-feeding.

Hygiene - Protective measures taken by individuals to promote health and limit the spread of infectious diseases. These measures include:

(1) washing hands with and running water after using the toilet, after using anything contaminated, and before eating or handling food;

(2) keeping hands, hair, and unclean items from the mouth, nose, eyes, ears, genitals and wounds;

(3) avoiding the common use of unclean utensils, drinking glasses, towels, handkerchiefs, combs, and hairbrushes;

(4) avoiding exposure to droplets from the noses and mouths of other people, as the droplets spread by coughing or sneezing;

(5) washing hands thoroughly after caring for another person; and

(6) keeping the body clean by frequent (daily) bathing or showering, using soap and water.

IFSP - *See* Individualized Family Service Plan.

Immune globulin (Gamma globulin, immunoglobulin) - An antibody preparation made from human plasma. It provides temporary protection against diseases such as hepatitis type A. Health officials may wish to give doses of immune globulin to children in child care facilities when cases of hepatitis appear.

Immunizations - Vaccines that are given to children and adults to help them develop protection (antibodies) against specific infections. Vaccines may contain an inactivated or killed agent or a weakened live organism. Childhood immunizations include protection against diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, and Haemophilus influenzae type b. Adults need to be protected against measles, rubella, mumps, polio, tetanus, and diphtheria.

Individualized Family Service Plan - A program, formalized in P.L. 99-457, Early Intervention Amendments to the Education for All Handicapped Children Act, formulated in collaboration with the family to meet the needs of a child with a developmental disability or delay, to assist the family in its management of the child, and to deal with the family's needs to the extent to which the family wishes assistance.

Infant - A child between the time of birth and the age of ambulation, usually 0 to 12 months.

Infection - A condition caused by the multiplication of an infectious agent in the body.

Infectious - Capable of causing an infection.

Infested - Having parasites (such as lice or scabies) living on the outside of the body.

Influenza ("flu") - An acute viral infection of the respiratory tract. Symptoms usually include fever, chills, headache, muscle aches, dry cough, and sore throat. Influenza should not be confused with Haemophilus influenzae infection caused by bacteria, or with "stomach flu," which is usually an infection caused by a different type of virus.

Injury, intentional - Physical damage to a human being resulting from an act done by design including a transfer of energy (physical, chemical, or heat energy).

Injury, unintentional - Physical damage to a human being resulting from an unplanned act event involving a transfer of energy (physical, chemical, or heat energy).

IPV - Abbreviation for inactivated polio virus, as in the inactivated (Salk type) polio virus vaccine.

Large family child care home - Usually, care and education for 7 to 12 children (including preschool children of the caregiver) in the home of the caregiver who employs one or more qualified adult assistants to meet the child:staff ratio requirements. This type of care is likely to resemble center care in its organization of activities. Shortened here to "large family home" or "large family home caregiver."

Lethargy - Unusual sleepiness.

Lice - Parasites that live on the surface of the human body (in head, body, or pubic hair). Louse infestation is called pediculosis.

Measles (red measles, rubeola, hard measles, 8 - 10 day measles) - A serious viral illness characterized by a red rash, high fever, light-sensitive eyes, cough, and cold symptoms.

Meninges - The tissue covering the brain and spinal cord.

Meningitis - A swelling or inflammation of the tissue covering the spinal cord and brain (meninges), usually caused by a bacterial or viral infection.

Meningococcal disease - Pneumonia, arthritis, meningitis, or blood infection caused by the bacterium Neisseria meningitidis.

Midinfancy - The first 6 to 7 months of life.

MMR - Abbreviation for the vaccine against measles, mumps, and rubella.

Mumps - A viral infection with symptoms of fever, headache, and swelling and tenderness of the salivary glands, causing the cheeks to swell.

NFPA - Abbreviation for the National Fire Protection Association, which provides specific guidance on public safety from fire in buildings and structures.

Nutrition specialist - As defined in these standards, a registered dietitian with 1 to 2 years' experience in infant and child health programs and coursework in child development, who serves as local or state consultant to child care staff.

OPV - Abbreviation for oral polio virus, as in trivalent (Sabin-type) polio virus vaccine.

OSHA - Abbreviation for the Occupational Safety and Health Administration of the U.S. Department of Labor, which administers the Occupational Safety and Health Act, regulating health and safety in the workplace.

Parasite - An organism that lives on or in another living organism (e.g., ticks, lice, mites).

Pediatric first aid - Emergency care and treatment of an injured child before definite medical and surgical management can be secured. Pediatric first aid includes rescue breathing and first aid for choking. (*See* First Aid and CPR.)

Pertussis - A highly contagious bacterial respiratory infection, which begins with cold-like symptoms and cough and becomes progressively more severe, so that the person may experience vomiting, sweating, and exhaustion with the cough. Although most older children and adults with pertussis whoop with coughing spells (hence the common term "whooping cough"), infants with pertussis commonly do not whoop but experience apneic spells, during which the infant becomes blue and stops breathing. The cough and apnea may persist for 1 to 2 months.

Pneumonia - An infection of the lungs.

Poliomyelitis - A disease caused by the polio virus with signs that may include paralysis and meningitis, but often with only minor flulike symptoms.

Potable - Suitable for drinking.

Preschooler - A child between the age of toilet training and the age of entry into a regular school; usually 36 to 59 months.

Rescue breathing - The process of breathing air into the lungs of a person who has stopped breathing, also called "artificial respiration."

Respiratory system - The nose, ears, sinuses, throat, and lungs.

Rifampin - An antibiotic often prescribed for those exposed to an infection caused by Haemophilus influenzae type b (Hib) or Neisseria meningitidis (meningococcus), or given to treat a person for a tuberculosis infection.

Rotavirus - A viral infection that causes diarrhea, vomiting, and cold symptoms.

Rubella (German measles, 3-day measles, light measles) - A mild viral illness with symptoms of red rash, low-grade fever, swollen glands, and sometimes achy joints. The rubella virus can infect and damage a fetus if the mother is not immune to the disease.

Salmonellosis - An infection called "food poisoning," with symptoms of vomiting, diarrhea, and abdominal pain; caused by the Salmonella bacteria.

Sanitize - To remove filth or soil and small amounts of certain bacteria. For an inanimate surface to be considered sanitary, the surface must be clean (*See* Clean) and the number of germs must be reduced to such a level that disease transmission by that surface is unlikely. This procedure is less rigorous than disinfection (*See* Disinfect) and is applicable to a wide variety of routine housekeeping procedures involving, for example, bedding, bathrooms, kitchen countertops, floors and walls. Soap, detergent, or abrasive cleaners may be used to sanitize. A number of EPA-registered "detergent sanitizer" products are also appropriate for sanitizing. Directions on product labels should be followed closely.

Scabies - A skin disease popularly called "the itch," caused by a tiny parasite that burrows into the skin, particularly on the front of the wrist, the webs and sides of the fingers, the buttocks, the genitals, and the feet, and causes intense itching.

School-age child - A child who is enrolled in a regular school, including kindergarten, usually from 5 to 12 years of age.

School-age child care facility - A center offering a program of activities before and after school and/or during vacations.

Shigellosis - A diarrheal infection caused by the Shigella bacterium.

SIDS - *See* Sudden Infant Death Syndrome.

Small family child-care home - Usually, the care and education of one to six children (including preschool children of the caregiver) in the home of the caregiver. Caregivers model their programs either on a nursery school or on a skilled parenting model. Applicable terms are abbreviated here to "small family home" or "family home caregiver."

Small family child-care home network - A group of small family child-care homes in one management system.

Staff - Used here to indicate all personnel employed at the facility, including caregivers and personnel who do not provide direct care to the children (cooks, drivers, housekeeping personnel, etc.).

Staphylococcus - A common bacterium found on the skin of healthy people that may cause skin infections or boils.

Streptococcus - A common bacterium that can cause sore throat, upper respiratory illnesses, pneumonia, skin rashes, skin infections, arthritis, heart disease (rheumatic fever), and kidney disease (glomerulonephritis).

Substitute staff - Caregivers (often without prior training or experience) hired for one day or for an extended of time who work under direct supervision of a trained licensed/certified *(see Qualifications)* permanent caregiver. (*See* Substitutes, for a full description of qualifications and responsibilities.)

Sudden Infant Death Syndrome (SIDS) - The sudden and unexpected death of an apparently healthy infant, typically occurring between the ages of 3 weeks and 5 months and not explained by an autopsy.

Syrup of ipecac - A type of medicine that induces vomiting in a person who has swallowed a toxic or poisonous substance.

TB - *See* Tuberculosis.

Toddler - A child between the age of ambulation and the age of toilet training, usually one aged 13 to 35 months.

Tuberculosis (TB) - A disease caused by the bacterium Mycobacterium tuberculosis that usually causes an infection of the lungs.

Universal precautions - A term that describes the infectious control precautions recommended by the Centers for Disease Control and Prevention to be used in all situations to prevent transmission of blood borne germs (e.g. human immunodeficiency virus, hepatitis B virus). These precautions are described in the publication Morbidity and Mortality Weekly Report (38, S-6), June 23, 1989. *See also* Disinfect and Sanitize on handling body fluids not visibly contaminated with blood.

Virus - A microscopic organism, smaller than a bacterium, that may cause disease. Viruses can grow or reproduce only in living cells.

Volunteer - In general, a regular member of the staff who is not paid and is not counted in the child: staff ratio (*See* Child staff ratio and Group size). If the volunteer is counted in the child - staff ratio, he/she must be 16 years or older and preferably work 10 hours or more in the facility.

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Appendix A

Research Methodology

Richard Fiene, Ph.D.

A modified Delphi approach was the research methodology employed to accomplish the task of deciding which standards to include in *Stepping Stones to Using Caring for Our Children*. The process included ten important components which are discussed below.

Eight chapters. *Caring for Our Children* is organized into eight chapters: staffing; program: activities for healthy development; program: health protection and health promotion; nutrition and food service; facilities, supplies, equipment, and transportation; infectious diseases; children with special needs, and administration. A ninth chapter includes recommendations for licensing and community action.

Ten technical areas. The original work done on development of the national health and safety standards involved ten technical areas: environmental quality, prevention and control of infectious diseases, injury management of child abuse, staff health, children with special needs, health concerns related to social environment and child development, and health and safety organization and administration. The eight chapters had to be crosswalked to the ten technical areas for analytical purposes. Every standard was placed within one of the ten technical areas.

Standards into items. The standards are written so that several concepts are embedded in each standard. Therefore, each standard had to be broken into discrete items so that when individuals rated each standard, they could more easily measure one concept at a time. This increased the pool of 981 standards to approximately 4,000 items.

Surveys. Once the items were developed, specific surveys were designed for the ten technical areas. These surveys utilized an 8-point Likert-type scale in which 1 represented a low risk and 8 represented a high risk. The scale was based on the risk to a child physically or psychologically or both. (A morbidity measure has to take into account the risk to both physical and psychological health of the child and staff when compliance with the item is lacking.) A rating of 1 indicated that the respondent believed non-compliance with the item presents minimal risk. A rating of 8 indicated that the respondent believed noncompliance with the item places the child and/or staff at high risk (both physically and psychologically).

Technical review panel. Surveys were sent to 342 content experts in the respective ten technical areas. Specific surveys were sent to experts representing the specific area of expertise. No one individual received the total packet of surveys. For example, the environmental quality surveys were sent only to individuals with expertise in environmental quality.

Data entry and analysis. Surveys were received from 256 of the 342 content experts (75% response rate). The surveys were coded and analyzed. All data were entered by the ten technical areas and analyzed accordingly.

Items aggregated into standards. All 4,000 items were aggregated back into the 981 standards according to the ten technical areas.

Rank ordering. Once the data were aggregated, the standards were rank-ordered by greatest risk to least risk for each of the ten technical areas.

Different approaches. With all the data rank-ordered for the ten technical areas, additional analyses were performed to reduce the number remaining to approximately 100. Three approaches were used. (1) Select the priority standards on the basis of a flat top ten standards across each technical area; (2) select the top standards proportionately across each technical area by the number of total standards in each of the ten technical areas; (3) select the top standards regardless of the technical area by only the relative weight of the standard. A combination of the three approaches finally was used, resulting, ultimately, in 182 standards being included.

National comparison matrix (NCM). During the research phase of this project, the document being developed was referred to as the National Comparison Matrix (NCM). The NCM was reviewed by a selected executive review panel with representation from the major national groups which had participated in the original weighting survey. This review process resulted in several drafts, the last of which contained 200 standards organized by key concept areas. This number has subsequently been reduced to 182 and is now published as *Stepping Stones to Using Caring for Our Children*.

Appendix B

Recommended Childhood Immunization Schedule

Please note that this schedule is subject to change upon recommendation by the Advisory Committee on Immunization Practices (ACIP) at the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). Please verify with your State Health Department that the Immunization Schedule you are following is the most current.

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[1]This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. Some combination vaccines are available and may be used whenever administration of all components of the vaccine is indicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

[2]***Infants born to HBsAg-negative mothers*** should receive 2.5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B®) or 10 µg of SB vaccine (Engerix-B®) at a separate site. The 2nd dose should be administered ≥1 mo after the 1st dose.

Infants born to HBsAg-positive mothers should receive 0.5 mL hepatitis B immune globulin (HBIG) within 12 hrs of birth, and either 5 µg of Merck vaccine (Recombivax HB®). The 2nd dose is recommended at 1-2 mos of age and the 3rd dose at 6 mos of age.

Infants born to mothers whose HBsAg status is unknown should receive either 5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SB vaccine (Engerix-B®) within 12 hrs of birth. The 2nd dose of vaccine is recommended at 1 mo of age and the 3rd dose at 6 mos of age. Blood should be drawn at the time of delivery to determine the mother's HBsAg status; if it is positive, the infant should receive HBIG as soon as possible (no later than 1 wk of age). The dosage and timing of subsequent vaccine doses should be based upon the mother's HBsAg status.

[3]Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any childhood visit. Those who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series during the 11-12 year-old visit. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered at least 4 mos after the 1st dose, and at least 2 mos after the 2nd dose.

[4]DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received ≥ dose of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose of DTaP may be administered as early as 12 mos of age, provided 6 mos have elapsed since the 3rd dose, and if the child is considered unlikely to return at 15-18 mos of age. Td (tetanus and diphtheria toxoids, adsorbed, for adult use) is recommended at 11-12 yrs of age if at least 5 yrs have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 yrs.

[5]Three *H. influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® [Merck]) is administered at 2 and 4 mos of age, a dose at 6 mos is not required. After completing the primary series, any Hib conjugate vaccine may be used as a booster.

[6]Two poliovirus vaccines are currently licensed in the US: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable by the ACIP, the AAP, and the AAFP, and parents and providers may choose among them:

1. IPV at 2 and 4 mos; OPV at 12-18 mos and 4-6 yrs
2. IPV at 2, 4, 12-18 mos, and 4-6 yrs
3. OPV at 2, 4, 6-18 mos, and 4-6 yrs

The ACIP routinely recommends schedule 1. IPV is the only poliovirus vaccine recommended for immunocompromised persons and their household contacts.

[7]The 2nd dose of MMR is routinely recommended at 4-6 yrs of age or at 11-12 yrs of age, but may be administered during any visit, provided at least 1 mo has elapsed since receipt of the 1st dose, and that both doses are administered at or after 12 mos of age.

[8]Susceptible children may receive Varicella vaccine (Var) during any visit after the 1st birthday, and unvaccinated persons who lack a reliable history of chickenpox should be vaccinated during the 11-12 year-old visit. Susceptible persons ≥ 13 years of age should receive 2 doses, at least 1 mo apart.